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ABSTRACT

This KIDS COUNT databook is the sixth annual profile examining statewide trends in the well-being of Rhode Island's children. The statistical portrait is based on 37 indicators in 5 areas: (1) family and community (covering child population and children in single-parent families); (2) economic well-being (covering median household income, cost of rent, children receiving child support, children in poverty, children in the Family Independence Program, children in families receiving food stamps, and children receiving school breakfast); (3) health (covering children's health insurance; access to dental care; women and children receiving WIC; women with delayed prenatal care; low birth weight infants; infant mortality; children with lead poisoning; births to teens; alcohol, drug, and cigarette use by teens; children with asthma; and additional children's health issues); (4) safety (covering child deaths, teen deaths, homeless children, homeless youth, juveniles referred to family court, children and domestic violence, and child abuse and neglect); and (5) education (covering infant and preschool child care, children enrolled in Head Start, school-age child care, children receiving child care subsidies, full-day kindergarten, fourth-grade reading proficiency, children enrolled in special education, school attendance, suspensions, high school graduation rate, and teens not in school

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and not working). The report defines each indicator, describes its significance and trends, provides information on intervention programs, and presents relevant data for the state, each city and town, and an aggregate of the five cities with the highest child poverty rates. The report concludes with a description of the methodology and acknowledgements. (EV)

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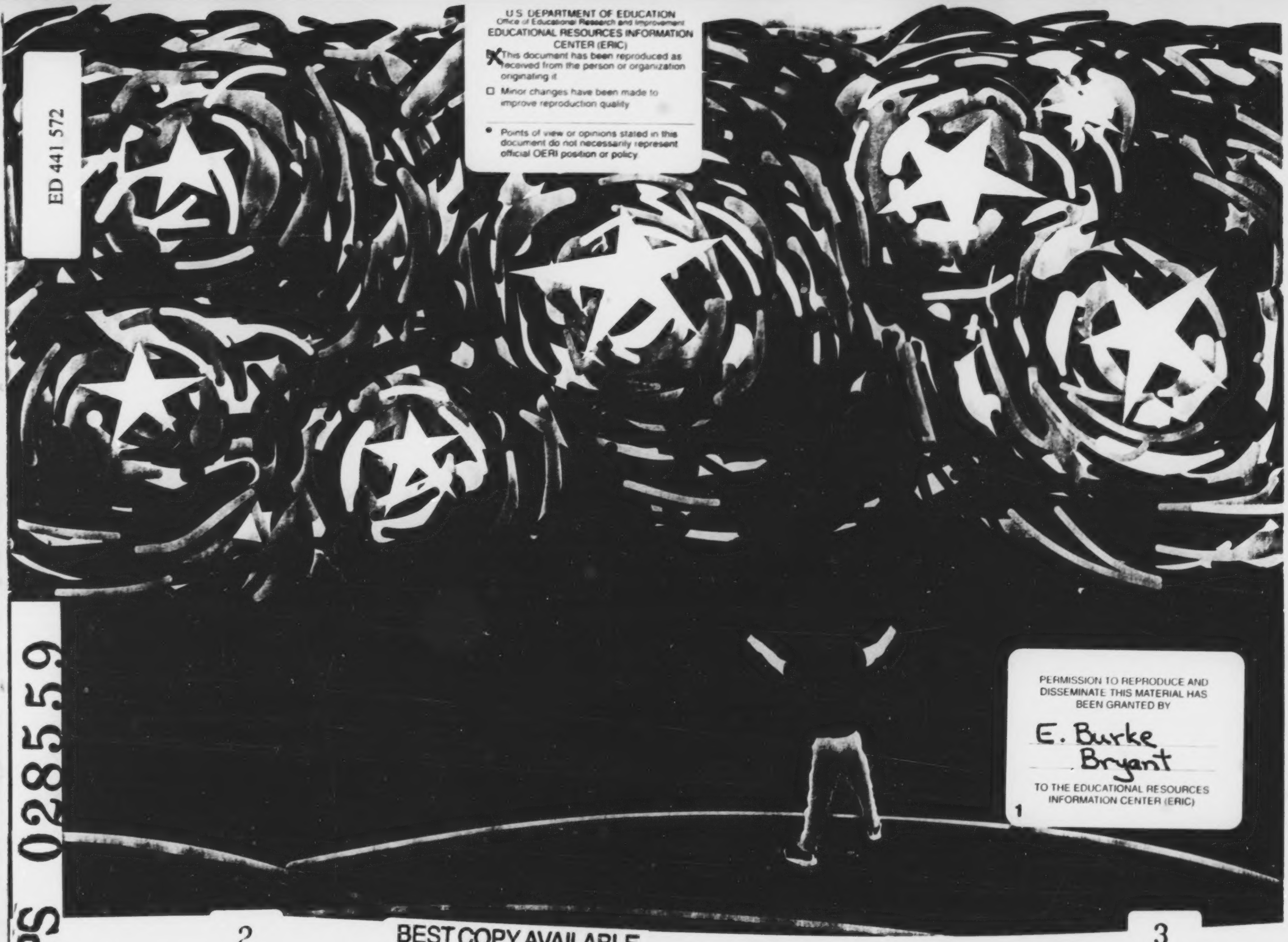

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2000 Rhode Island Kids Count Factbook

Rhode Island KIDS COUNT is a children's policy and education organization that provides information on child well-being, stimulates dialogue on children's issues, and promotes accountability and action. Primary funding for Rhode Island KIDS COUNT is provided by The Rhode Island Foundation and The Annie E. Casey Foundation. Additional funding is provided by the United Way of Southeastern New England, Prince Charitable Trusts, the Northeast and Islands Regional Educational LAB at Brown University, Carnegie Corporation of New York, The Robert Wood Johnson Foundation and other corporate, foundation and individual sponsors.

The annual *Rhode Island KIDS COUNT Factbook* is one of many state level projects designed to provide a detailed community-by-community picture of the condition of children. A national Factbook with comparable data for the U.S. is produced annually by The Annie E. Casey Foundation.

Additional copies of the *2000 Rhode Island KIDS COUNT Factbook* are available for $15.00 per copy. Reduced rates are available for bulk orders. To receive copies of the *2000 Factbook*, please contact:

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2000 Rhode Island KIDS COUNT Factbook
Rhode Island KIDS COUNT, Providence, RI

2000 Rhode Island KIDS COUNT Factbook

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**New Indicator*

Overview

Stars

Alone in the night
On a dark hill
With pines around me
Spicy and still,

And a heaven full of stars
Over my head,
White and topaz
And misty red;

Myriads with beating
Hearts of fire
That aeons
Cannot vex or tire;

Up the dome of heaven
Like a great hill,
I watch them marching
Stately and still,

And I know that I
Am honored to be
Witness
Of so much majesty.

– Sara Teasdale

Overview

The *2000 Rhode Island KIDS COUNT Factbook* is the sixth annual profile of the well-being of children in Rhode Island. The annual Factbook is an important tool for planning and action by community leaders, policy makers, advocates, and others working toward changes that will improve the quality of life for all of Rhode Island's children.

The annual Factbook tracks progress across five areas of child well-being. All areas of child well-being are interrelated and critical throughout a child's development. A child's safety in his family and community affects his school performance; a child's economic security affects her health and education. The *2000 Rhode Island KIDS COUNT Factbook* reflects these interrelationships and builds a framework to guide children's policy, programs for children and families, and individual service on behalf of children.

The *2000 Rhode Island KIDS COUNT Factbook* provides a statistical portrait of the status of Rhode Island's children. Information is presented for the state of Rhode Island, each city and town, and an aggregate of the five cities in which more than 15% of the children live in poverty. These cities — referred to as the "core cities" in the Factbook — are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

By examining the best available data statewide and in Rhode Island's 39 cities and towns, Rhode Island KIDS COUNT provides an information base that can result in more effective policy and community action on behalf of children. The *2000 Rhode Island KIDS COUNT Factbook* examines thirty-seven indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. Seven new indicators are included in this edition of the Factbook. The most current and reliable data available are presented for each indicator.

Healthy Communities

The Factbook provides community-level information on each indicator in order to emphasize the significance of the surrounding physical, social, and economic environment in shaping outcomes for children. Communities and neighborhoods do matter — the actions of community leaders, parents, individuals, businesses, government leaders, and elected officials greatly influence children's chances for success and the challenges they will face. Tracking changes in selected indicators can help communities to set priorities, identify strategies to reverse negative trends, and monitor progress.

Family Economic Well-being

Children most at risk of not achieving their full potential are children in poverty. Despite overall economic growth in the past decade, many Rhode Island families have experienced income losses since the late 1980s. The child poverty rate in Rhode Island has increased from 14% in 1990 to 18% in 1997. The high costs of child care, health care and housing make it difficult for many families — even those with incomes above the official poverty level — to make ends meet. Child care subsidies, health care subsidies, affordable housing, and tax policies that support working families are critical tools to ensure the economic well-being of Rhode Island families.

Results for All Children

Improving outcomes for all children requires concerted attention to improving outcomes for Rhode Island's Black, Hispanic, Asian and Native American children. While three-quarters of Rhode Island's poor children are white, children of color are three times more likely to be poor and more likely to live in Rhode Island's poorest urban neighborhoods. Significant disparities in child outcomes continue to exist between minority children and white children in Rhode Island. Strategic efforts that engage diverse leadership from all sectors can ensure that all Rhode Island children have the resources they need to thrive, including economic security, affordable housing, quality health care, quality child care, effective schools, and caring communities.

Family and Community

from Warrior Nation Trilogy
(Cheyenne)

from the mountains we come
lifting our voices for the beautiful
road you have given

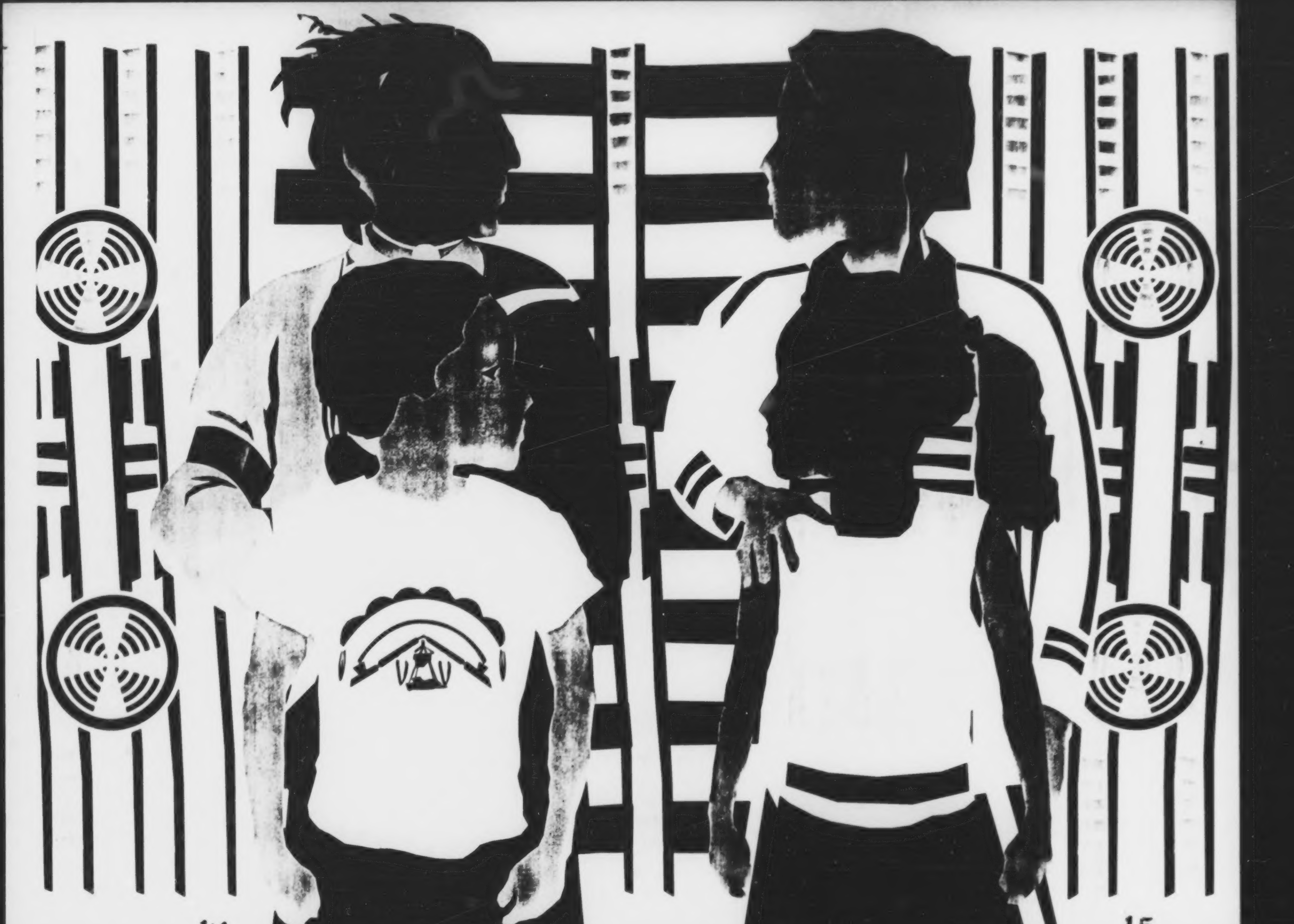
we are the buffalo people
we dwell in the light of our father sun
in the shadow of our mother earth

we are the beautiful people
we roam the great plains without fear
in our days the land has taught us oneness
we alone hear the song of the stones

oh ghost that follows me
find in me strength to know the wisdom
of this life

take me to the mountain of my grandfather
i have heard him all night
singing among the summer leaves

– Lance Henson



Child Population

DEFINITION

Child population is the percentage of the total population that is under the age of 18.

SIGNIFICANCE

In 1997, one-quarter of the Rhode Island population was under age 18. There were 222,358 Rhode Island children under age 18.[1] Of these, 6% were infants less than age one; 27% were ages 1 to 5; 35% were ages 6 to 11; and 33% were ages 12 to 17.[2] Over the next decade the number of Rhode Island teenagers will grow by 20%, while the number of younger children ages birth to 12 will drop by 2%.[3]

Since 1960, American family size has been decreasing. In 1998 the average family had three members.[4] Between 1960 and 1997, the percentage of families with four or more children under age 18 decreased from 9% to 3%.[5] In 1997, 68% of Rhode Island children lived with both parents, 26% lived with their mother only, and 3% lived with their father only.[6]

Rhode Island's children are diverse in race, ethnic background, language, and country of origin. Children under age 18 are significantly more diverse in racial and ethnic backgrounds than the adult population. In 1997, 89.2% of Rhode Island children were white, 6.5% were black, 2.7% were Asian, and less than 1% were American Indian. Of Rhode Island's 222,358 children, 10.5% were Hispanic.[7]

Rhode Island, and the U.S. as a whole, will continue to grow more diverse into the next century. According to U.S. Census Bureau projections, the Hispanic population will become the largest minority group in the U.S. by 2005. The Asian population is the fastest growing group in the United States. By 2050, Hispanics will make up 24% and Asians will make up 9% of the total U.S. population.[8]

Minority Children and the Decennial Census

- **Minorities are more likely than non-Hispanic whites to be undercounted in the U.S. Census conducted every ten years. Minority children are the most likely group to be undercounted, and minority children will comprise more than one-third of the children in the 2000 U.S. Census.[9]**

- **An accurate Census count is critical for long-range planning of services for children, especially in urban areas with large minority populations.[10]**

- **According to the 1990 Census, 16% of Rhode Island children were Black, Asian, Native American, and/or Hispanic. In the core cities, 39% of children were of a racial or ethnic minority group as compared to 5% of children in the remainder of state.[11]**

- **In 1990, minority children comprised 56% of children under age 18 in Providence, 49% in Central Falls, 21% in Pawtucket, 19% in Newport, and 15% in Woonsocket.[12]**

Race/Ethnicity of Rhode Island Children, 1997 and 2005

	1997	2005	% Change
White, Non-Hispanic	190,600	179,700	-6%
Black	12,100	16,000	+32%
Hispanic	22,700	34,400	+52%
Asian and Pacific Islander	6,900	12,100	+75%
Native American	1,300	2,100	+62%

Source: *1999 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1999). Baltimore, MD: The Annie E. Casey Foundation. The 1997 figure represents Census Bureau projections as of July 1, 1997, while the 2005 figure represents the Census Bureau's projections as of July 1, 2005.

Table 1.

Child Population, Rhode Island, 1999

CITY/TOWN	TOTAL POPULATION	CHILDREN UNDER AGE 18	
		#	%
Barrington	15,946	3,896	24%
Bristol	21,495	4,317	20%
Burrillville	14,797	4,215	28%
Central Falls	16,236	4,603	28%
Charlestown	7,536	1,795	24%
Coventry	31,044	7,682	25%
Cranston	72,761	14,079	19%
Cumberland	28,287	6,338	22%
East Greenwich	11,007	2,653	24%
East Providence	48,645	10,351	21%
Exeter	5,983	1,672	28%
Foster	4,304	1,175	27%
Glocester	8,247	2,257	27%
Hopkinton	7,560	2,035	27%
Jamestown	5,368	1,228	23%
Johnston	25,510	5,294	21%
Lincoln	18,265	3,918	21%
Little Compton	3,265	701	21%
Middletown	17,359	4,487	26%
Narragansett	17,019	3,206	19%
Newport	25,890	5,437	21%
New Shoreham	834	178	21%
North Kingstown	26,900	6,809	25%
North Providence	31,142	5,641	18%
North Smithfield	9,722	2,088	21%
Pawtucket	69,613	16,093	23%
Portsmouth	17,705	4,387	25%
Providence	152,698	37,195	24%
Richmond	5,580	1,610	29%
Scituate	10,845	2,635	24%
Smithfield	19,451	3,958	20%
South Kingstown	26,432	5,152	19%
Tiverton	13,746	2,988	22%
Warren	11,582	2,487	21%
Warwick	86,240	18,811	22%
Westerly	24,128	5,666	23%
West Greenwich	4,341	1,147	26%
West Warwick	29,195	6,696	23%
Woonsocket	41,175	10,101	25%
Core Cities	***305,612***	***73,429***	***24%***
Remainder of State	***682,241***	***151,552***	***22%***
Rhode Island	***987,853***	***224,981***	***23%***

Source of Data for Table/Methodology

GeoLytics estimates for 1999 using data from the U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the total number of children under age 18 in 1999 according to GeoLytics estimates using data from the U.S. Bureau of the Census, 1990 Census of Population.

See methodology on page 96 for additional information on GeoLytics estimates.

References for Indicator

[1,2,6,7] U.S. Bureau of the Census, Current Population Survey 1995 to 1999.

[3] *1998 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1998). Baltimore, MD: The Annie E. Casey Foundation.

[4] U.S. Census Bureau (March 1998). *Current Population Reports: Household and Family Characteristics.* Washington, DC: U.S. Department of Commerce.

[5] *Trends in the Well-Being of America's Children and Youth* (1998). Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation and Child Trends, Inc.

[8] U.S. Department of Commerce News. *Census Bureau Projects Doubling of the Nation's Population by 2100.* (January 13, 2000).

[9] O'Hare, W. P. (1999). "The Overlooked Undercount: Children Missed in the Decennial Census," *KIDS COUNT Working Paper.* Baltimore: The Annie E. Casey Foundation.

[10] Pollard, K. M. and O'Hare, W.P. (September 1999). "America's Racial and Ethnic Minorities" in *Population Bulletin*, Vol. 54, No. 3. Washington, DC: Population Reference Bureau.

[11,12] U.S. Bureau of the Census, 1990 Census of Population. Minority is defined here by the race and ethnicity categories used in the 1990 Census and includes children under age 18 identified by Census data as Black, Asian, Native American, and/or Hispanic.

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Children in Single Parent Families

DEFINITION

Children in single parent families is the percentage of children under age 18 who live in families headed by a person — male or female — without a spouse present in the home. These numbers include "own children" defined as never-married children under 18 who are related to the family head by birth, marriage, or adoption.

SIGNIFICANCE

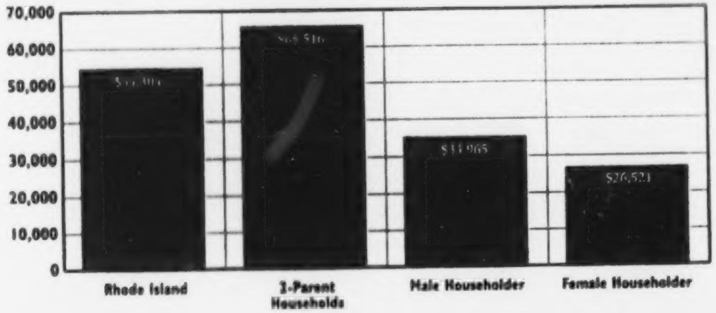
Although most Rhode Island children live with two parents, 29% lived in a single parent family in 1997.[1] This includes 26% of white children, 59% of Black children, and 51% of Hispanic children. Black and Hispanic children in Rhode Island are twice as likely to live in a single parent family as white children.[2]

The proportion of children living with one parent has almost doubled since 1970. The increase in single parent families over the past three decades has occurred across all races and income levels.[3] According to the Center for Demographic Policy in Washington DC, 60% of all children in the United States will spend some time in a single parent family before reaching age 18.[4]

Nationally, of the children living with one parent, 38% live with a divorced parent, 35% live with a never-married parent, 19% live with a separated parent, 4% with a widowed parent and 4% have a parent who lives elsewhere because of business or some other reason.[5] Never-married parents are significantly younger than divorced parents and on average tend to have fewer years of school completed and lower levels of income.[6] In 1998 in Rhode Island, 34% of all births were to unmarried women.[7]

Compared with teenagers who grow up with both parents at home, adolescents who have lived apart from one of their parents during some period of their childhood are twice as likely to drop out of school, twice as likely to have a child before age 20, and one and a half times more likely to be out of school and out of work in their teens and early twenties. These effects are found regardless of race and maternal education.[8] Youth who thrive in single parent families are almost twice as likely as those who do not thrive to report feeling support from their family, turning to a parent for social support, having a parent involved in schooling, and having explicit parental standards.[9]

Average Household Income for Families with Children, Rhode Island, 1997



◆ **In 1997, the average household income in Rhode Island for two parent families with children was $65,516 compared to $34,965 for single parent families headed by a man and $26,521 for single parent families headed by a woman.**

Source: U.S. Bureau of the Census, Current Population Survey, 1995 to 1999 average.

Single Parent Families and Poverty

◆ **Children in single parent families are at increased risk of living in poverty when compared to children in two parent families.**

◆ **In 1997, just under half (46%) of Rhode Island's single parent families with children were living below the poverty line, as compared to 4% of two parent families with children.[10]**

◆ **In 1997 in Rhode Island, 70% of children living below the poverty line lived with a single mother.[11]**

Table 2

Children's Living Arrangements, Rhode Island, 1990

CITY/TOWN	TOTAL FAMILY HOUSEHOLDS WITH CHILDREN UNDER 18	NUMBER OF CHILDREN UNDER 18 YEARS			
		TWO-PARENT FAMILY		SINGLE PARENT FAMILY	
		N	%	N	%
Barrington	2,035	3,514	94.4%	207	5.6%
Bristol	2,300	3,660	88.9%	457	11.1%
Burrillville	2,314	3,824	87.2%	560	12.8%
Central Falls	2,373	2,859	61.7%	1,778	38.3%
Charlestown	833	1,244	83.0%	254	17.0%
Coventry	3,979	6,290	87.2%	920	12.8%
Cranston	7,911	11,360	81.2%	2,622	18.8%
Cumberland	3,491	5,551	90.2%	604	9.8%
East Greenwich	1,609	2,521	88.3%	335	11.7%
East Providence	5,766	7,950	81.7%	1,776	18.3%
Exeter	768	1,278	90.6%	132	9.4%
Foster	591	988	88.2%	132	11.8%
Glocester	1,320	2,036	88.6%	261	11.4%
Hopkinton	930	1,557	90.2%	170	9.8%
Jamestown	623	907	83.4%	181	16.6%
Johnston	2,851	4,229	81.7%	945	18.3%
Lincoln	2,181	3,210	86.1%	518	13.9%
Little Compton	420	612	89.7%	70	10.3%
Middletown	2,429	3,774	85.1%	659	14.9%
Narragansett	1,551	2,227	85.2%	387	14.8%
Newport	3,086	3,569	65.0%	1,920	35.0%
New Shoreham	97	149	88.7%	19	11.3%
North Kingstown	3,299	4,943	85.1%	864	14.9%
North Providence	3,115	4,563	86.6%	706	13.4%
North Smithfield	1,284	1,935	91.1%	188	8.9%
Pawtucket	8,957	11,266	73.9%	3,976	26.1%
Portsmouth	2,429	3,749	91.7%	339	8.3%
Providence	17,948	19,292	56.2%	15,054	43.8%
Richmond	791	1,344	94.9%	72	5.1%
Scituate	1,275	2,079	90.1%	228	9.9%
Smithfield	2,095	3,324	91.0%	330	9.0%
South Kingstown	2,603	3,681	81.8%	819	18.2%
Tiverton	1,727	2,477	84.0%	472	16.0%
Warren	1,356	1,880	83.8%	364	16.2%
Warwick	9,505	14,477	83.6%	2,835	16.4%
Westerly	2,746	4,071	85.7%	680	14.3%
West Greenwich	464	715	86.0%	116	14.0%
West Warwick	3,529	4,711	77.3%	1,386	22.7%
Woonsocket	5,650	6,850	68.6%	3,140	31.4%
Core Cities	*38,014*	*43,836*	*62.8%*	*25,868*	*37.1%*
Remainder of State	*80,217*	*120,830*	*85.4%*	*20,608*	*14.6%*
Rhode Island	*118,231*	*164,666*	*78.0%*	*46,476*	*22.0%*

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of children under age 18 according to the 1990 census.

References for Indicator

[1,2,10,11] U.S. Bureau of the Census, Current Population Survey, 1995 to 1999 average.

[3] U.S. Bureau of the Census, Census of Population, 1970, 1980, 1990.

[4] Hodgkinson, H. L. (1992). *A Demographic Look at Tomorrow*. Washington, DC: Institute for Educational Leadership, Center for Demographic Policy.

[5,6] U.S. Bureau of the Census (1997). *Census Brief: Children with Single Parent Families - How They Fare* (September 1997). Washington, DC: U.S. Department of Commerce, Bureau of the Census.

[7] Rhode Island Department of Health, Division of Family Health, Universal Newborn Screening Database, 1998.

[8] McLanahan, S. and Sandefur, G. (1994). *Growing Up With a Single Parent* as quoted in *KIDS COUNT Special Report - When Teens Have Sex: Issues and Trends* (1999). Baltimore, MD: Annie E. Casey Foundation.

[9] Benson, P.L. and Roehlkepartain, E.C. (1993). *Youth in Single Parent Families: Risk and Resiliency.* Minneapolis, MN: The Search Institute.

Economic Well-Being

Paraíso terrenal

¡cómo me gusta
venir al mercado
con mi abuela!

oler la frescura
de la mañana
en el cilantro

perderme
entre los mangos
y las papayas

las flores
de calabaza
y las sandías

¡cúanto color
cuánto sabor
en cada rincón!

¡sí, la tierra
sigue siendo
un paraíso!

– Francisco X. Alarcón

Earthly Paradise

how I enjoy
coming to *El Mercado*
with my grandma!

smelling the early
day's freshness
in the cilantro

getting lost
among the mangoes
and papayas

flowery
squash buds
and watermelons

so many colors
so many flavors
everywhere!

yes, the Earth
is still
a paradise!

Median Household Income

DEFINITION

Median household income is the median annual income for Rhode Island households. The median income is the dollar amount which divides the income distribution into two equal groups — half with income above the median and half with income below the median.

SIGNIFICANCE

The median household income provides one measure of the ability of Rhode Island's families to meet the costs of food, clothing, housing, health care, transportation, child care, and higher education. In 1997, 27% of Rhode Island households with children had a family income less than $25,000 and 10% of families had incomes between $25,000 and $35,000.[1]

In 1997, one-half of all Rhode Island families with children earned less than $44,856 and one-half earned more.[2] Recent increases in median family income nationally are largely the result of increases in total work hours — an additional six weeks annually for the typical family since 1989. Families have increased their income either by more family members working and/or by working more hours each year.[3,4]

Due to the tight labor market and the increase in the minimum wage, very low-paid workers experienced wage increases between 1996 and 1998.[5] Despite the increase in real wages that began in 1996, the wages of many low-income and middle-income families have not returned to 1989 levels. For men working full-time year-round, wages in 1997 were $1,500 below 1989 levels.[6] Women's earnings are below those for men in every occupational category for full-time, year-round workers.[7]

Several fundamental changes in the U.S. economy have led to stagnating wages among low- and middle-income workers. The manufacturing sector, which once provided relative prosperity for a broad middle class of unskilled and semi-skilled workers, is being replaced by low-paying service sector jobs.[8] In Rhode Island between 1988 and 1998, the number of service jobs increased by 39% while the number of manufacturing jobs decreased by 34%.[9] Of Rhode Island working parents with low hourly earnings, 41% work in service jobs, 25% are in retail trade, and 24% are in manufacturing.[10]

Median Household Income Increases with Education Level

◆ In the U.S. in 1996, men with at least a college degree had a median family income 2.7 times the median for men who did not complete high school.[11]

◆ Median family income for women with a college degree was three times as high as the median for women without a high school diploma.[12]

Income Trends Among Families with Children, Rhode Island, 1989 and 1997

INCOME GROUP	AVERAGE INCOME IN 1989	AVERAGE INCOME IN 1997	PERCENT CHANGE IN INCOME (ADJUSTED FOR INFLATION)
HIGHEST FIFTH OF FAMILIES	$125,030	$160,176	+28%
MIDDLE FIFTH OF FAMILIES	$51,823	$51,071	no change
LOWEST FIFTH OF FAMILIES	$17,307	$13,527	-22%

◆ Between the late 1980s and the late 1990s, the average incomes of Rhode Island families in the bottom fifth of the income distribution fell by $3,781, a decline of 22%. During the same time period, the richest fifth of families saw their incomes rise by $35,146, an increase of 28%.

◆ Of all 50 states, the gap between the richest 20% of families and the poorest 20% grew most in Rhode Island (followed by Oregon, Arizona, New York and Connecticut).

◆ In Rhode Island in the late 1980s, the top fifth of families had incomes seven times as large as the bottom fifth of families. By the late 1990s, the richest fifth of Rhode Island families had incomes almost 12 times as large as the poorest fifth of families.

◆ Rhode Island is one of 15 states in which high-income families had income gains over the past decade, while middle-income families had no income gains and low-income families had income losses.

Source: Bernstein, J., McNichol, E.C., Mishel, L. and Zahradnik, R. (January 2000). *Pulling Apart: A State-By-State Analysis of Income Trends.* Washington, DC: Center on Budget and Policy Priorities and the Economic Policy Institute. The 1989 figures represent 1988-1990 data from the Current Population Survey; the 1997 figures represent 1996-1998 data from the Current Population Survey.

Median Household Income

Earned Income Tax Credit Benefits Working Families

◆ The federal Earned Income Tax Credit (EITC) is a refundable credit on the federal income tax, available since 1975, to low-income and moderate-income working families with children.

◆ EITC increases the income available to working poor families. The maximum benefits for tax year 1999 are $2,312 for families with one child and $3,816 for families with two or more children. Benefits phase down gradually once income exceeds $12,460.[13]

◆ Many families with working parents remain poor even when their federal EITC benefits are considered. In addition, low-income families pay a substantial share of their incomes in state and local taxes, particularly regressive sales and excise taxes.[14]

◆ The state of Rhode Island is one of eleven states that have established state EITC programs that help to bring low-wage earners up to the poverty threshold. Of these, Rhode Island and two other states have non-refundable EITC programs.[15]

◆ When a state EITC is refundable, the family receives a refund check if the size of its EITC exceeds its tax bill. Refundable EITC programs maximize economic benefits to the lowest income families. By providing a supplement to earnings, refundable EITCs can lift families with below-poverty wages to incomes above the federal poverty line.[16]

Table 3.

Median Household Income, Rhode Island, 1990

CITY/TOWN	MEDIAN INCOME
Barrington	$53,058
Bristol	$34,165
Burrillville	$37,156
Central Falls	$18,617
Charlestown	$36,040
Coventry	$37,230
Cranston	$34,528
Cumberland	$40,683
East Greenwich	$50,896
East Providence	$31,007
Exeter	$38,179
Foster	$40,795
Glocester	$40,000
Hopkinton	$36,737
Jamestown	$41,518
Johnston	$32,596
Lincoln	$37,082
Little Compton	$41,187
Middletown	$35,228
Narragansett	$35,545
Newport	$30,534
New Shoreham	$31,471
North Kingstown	$40,419
North Providence	$32,321
North Smithfield	$41,449
Pawtucket	$26,541
Portsmouth	$42,474
Providence	$22,147
Richmond	$40,975
Scituate	$45,170
Smithfield	$42,523
South Kingstown	$36,481
Tiverton	$36,170
Warren	$31,637
Warwick	$35,786
Westerly	$34,844
West Greenwich	$41,250
West Warwick	$31,625
Woonsocket	$25,363
Core Cities	***NA***
Remainder of State	***NA***
Rhode Island	***$32,181***

Note to Table

In Rhode Island in 1997, the median household income for all households was $45,271 according to the U.S. Bureau of the Census, Current Population Survey, 1995-1999 average. Updated data are not available at the city and town level.

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population, 1989 dollars. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

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Cost of Rent

DEFINITION

Cost of rent is the percentage of income needed by a low-income renter to cover the average cost of rent, including heat. Rent burdens over 30% are considered unaffordable.[1] A low-income renter is defined as income 30% below the 1999 median renter income.[2]

SIGNIFICANCE

Inadequate, costly, or crowded housing has a negative impact on children's health, safety, education, and emotional well-being.[3] Housing that costs more than one-third of a family's income is considered to be unaffordable. Families paying higher percentages of their income for housing are likely to go without other basic necessities such as food and clothing in order to pay their rent (or mortgage) and utilities. Any interruption in income or unexpected expense can place families at risk of eviction, doubling-up with family members, or homelessness.[4] Children who move frequently are more likely to be absent from school, to fall behind in their school work, and to drop out of high school.[5,6]

Much of the state's rental housing stock is more than fifty years old. Many of the units that might be affordable to a low-income family are in need of repair. Housing and building code violations disproportionately affect low-income families. Common housing problems include roach and rodent infestation, lead exposure, faulty wiring, inadequate heating systems, plumbing problems, or lack of a kitchen sink, refrigerator, or stove. Children living in substandard housing are more at risk for injuries, lead poisoning, asthma, and malnutrition."[8]

While substandard housing is a problem in some neighborhoods, affordability is increasingly the primary problem faced by low-income families.[9] Data from the 1995 American Housing Survey indicate that the shortage of affordable housing for low-income renters is wider than ever before. Since the late 1980's the number of low-cost units has fallen and the number of low-income families has increased.[10] In 1995 in the U.S., only about one-third of renter households with incomes below the poverty line received a housing subsidy from the federal, state, or local government.[11] As of December 1999 in Rhode Island, 31% of households enrolled in the Family Independence Program were receiving housing assistance.[12]

Affordable Rents for Selected Income Levels, Rhode Island, 1999

Income Level	Annual Income 1999	Affordable Rent (30% of Income)
Median-Income Renter	$26,247	$656
Low-Income Renter	$18,373	$459
Poverty Level Family of Three	$13,880	$347
FIP Cash Assistance plus Food Stamps	$10,284	$257

◆ **In 1998, the average rent for a two-bedroom apartment in Rhode Island was $613, including heat.**

Source: Rhode Island Housing, January 2000. Calculations by Rhode Island KIDS COUNT

Housing Affordability is Related to...

◆ Family Income

Housing affordability problems are most likely among families with incomes below 150% of poverty (i.e. income less than $25,050 for a family of four).[14] In 1997, one in four (27%) Rhode Island families with children under age 18 had an annual income below $25,000.[15]

◆ Housing Costs

Between 1978 and 1995, the percentage of U.S. households with children who pay more than 30% of their income for housing rose from 15% to 28%.[16] The National Low-Income Housing Coalition estimates that 51% of Rhode Island renters are unable to afford a 2-bedroom apartment at the Fair Market rate of $673.[17]

◆ Housing Policy

The need for housing assistance among low-income families has increased while the availability of subsidies and affordable units in the private rental market have decreased.[18] In 1997 in the U.S., for every 100 households at or below the poverty level, there were only 36 units both affordable and available for rent.[19] In Rhode Island, there are nearly two low-income renters for every low-rent unit.[20]

Cost of Rent

Table 4.

Cost of Rental Housing for Low-Income Families, Rhode Island, 1999

CITY/TOWN	1998 AVERAGE RENT 2-BEDROOM	1999 LOW-INCOME RENTER	% INCOME NEEDED FOR RENT LOW-INCOME RENTER	1999 POVERTY LEVEL FAMILY OF THREE	% INCOME NEEDED FOR RENT POVERTY LEVEL FAMILY OF THREE
Barrington	$801	$18,373	52%	$13,880	69%
Bristol	$571	$18,373	37%	$13,880	49%
Burrillville	$650	$18,373	42%	$13,880	56%
Central Falls	$493	$18,373	32%	$13,880	43%
Charlestown	$716	$18,373	47%	$13,880	62%
Coventry	NA	$18,373	NA	$13,880	NA
Cranston	$642	$18,373	42%	$13,880	56%
Cumberland	$600	$18,373	39%	$13,880	52%
East Greenwich	$843	$18,373	55%	$13,880	73%
East Providence	$651	$18,373	43%	$13,880	56%
Exeter	NA	$18,373	NA	$13,880	NA
Foster	NA	$18,373	NA	$13,880	NA
Glocester	NA	$18,373	NA	$13,880	NA
Hopkinton	NA	$18,373	NA	$13,880	NA
Jamestown	NA	$18,373	NA	$13,880	NA
Johnston	$592	$18,373	39%	$13,880	51%
Lincoln	$605	$18,373	40%	$13,880	52%
Little Compton	NA	$18,373	NA	$13,880	NA
Middletown	$618	$18,373	40%	$13,880	53%
Narragansett	$843	$18,373	55%	$13,880	73%
Newport	$760	$18,373	50%	$13,880	66%
New Shoreham	NA	$18,373	NA	$13,880	NA
North Kingstown	$659	$18,373	43%	$13,880	57%
North Providence	$624	$18,373	41%	$13,880	54%
North Smithfield	$675	$18,373	44%	$13,880	58%
Pawtucket	$551	$18,373	36%	$13,880	48%
Portsmouth	$846	$18,373	55%	$13,880	73%
Providence	$609	$18,373	40%	$13,880	53%
Richmond	$680	$18,373	44%	$13,880	59%
Scituate	NA	$18,373	NA	$13,880	NA
Smithfield	$756	$18,373	49%	$13,880	65%
South Kingstown	$660	$18,373	43%	$13,880	57%
Tiverton	$645	$18,373	42%	$13,880	56%
Warren	$539	$18,373	35%	$13,880	47%
Warwick	$672	$18,373	44%	$13,880	58%
Westerly	$669	$18,373	44%	$13,880	58%
West Greenwich	NA	$18,373	NA	$13,880	NA
West Warwick	$626	$18,373	41%	$13,880	54%
Woonsocket	$476	$18,373	31%	$13,880	41%
Core Cities	***$572***	***$18,373***	***37%***	***$13,880***	***49%***
Remainder of State	***$637***	***$18,373***	***42%***	***$13,880***	***55%***
Rhode Island	***$613***	***$18,373***	***40%***	***$13,880***	***53%***

Source of Data for Table/Methodology

Rhode Island Housing, January 1999. A low-income renter is defined as 30% below 1999 median renter income. Average rents are based on a biannual survey of rents in Rhode Island during 1998. Rents include the HUD allowance for heat, if heat was not included in the advertised rent. Rent burdens over 30% are considered unaffordable. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

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Children Receiving Child Support

DEFINITION

Children receiving child support is the percentage of non-custodial parents in the Rhode Island Child Support Enforcement System who pay child support on time and in full. The percentage does not include cases in which paternity has not been established. Court orders for child support require establishment of paternity.

SIGNIFICANCE

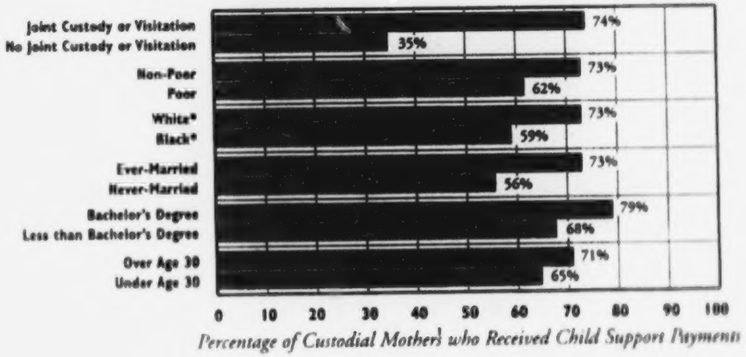
The goal of the child support system is to collect money from non-custodial parents so that their children can have adequate financial security as they grow up. For child support to be collected on behalf of a child, the non-custodial parent must be identified, paternity must be established, a support order must be entered, and the money must be collected. A child support order may include a provision that the non-custodial parent provide the child's health insurance in addition to cash support.[1]

The failure of a non-custodial parent to pay child support has significant economic consequences for the custodial parent and for the child. Children who live with only one parent are more likely to live with their mother and to be poor.[2] In Rhode Island, nearly one-third of all children live in a family with one parent absent.[3] For middle-income families receiving child support, the support payments account for 16% of their income; for poor families receiving child support, the support payments account for over one-quarter (26%) of their income.[4]

Stronger federal and state child support enforcement policies such as wage withholding, in-hospital paternity establishment, and tax intercept programs have resulted in an increased percentage of custodial parents receiving child support payments since the late 1970s.[5] Yet in 1995 in the U.S., 42% of all custodial parents had no awards for financial support from the child's other parent.[6]

Even when there is a child support order in place, child support payments tend to be low and unreliable. As of December 1999, there were 75,372 Rhode Island children in the State's Child Support Enforcement System. Of these, 19,916 (26%) have not yet had paternity established and therefore are not yet eligible for a child support award. In 1999 in Rhode Island, 40% of Rhode Island non-custodial parents under court order paid child support on time and in full. As of December 31, 1999, the amount of past due court-ordered child support in Rhode Island totaled $232 million.[7]

Receipt Rates for Child Support Payments, by Selected Characteristics of Custodial Mother, United States, 1995



Source: Census Bureau (March 1999). *Child Support for Custodial Mothers and Fathers: 1995.* Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration. All data are for custodial mothers only.
*Data for other race/ethnic groups are not available.

◆ Parents who have regular contact with their children are more likely to pay child support. In 1995 in the United States, 74% of parents who had either joint custody or visitation privileges paid child support compared to 35% who did not have regular contact.[8]

◆ Of women due child support in 1995, the percentage of custodial mothers with incomes below the poverty line who received child support payments was 62%, compared to 73% of non-poor custodial mothers who received child support payments.[9]

◆ Low-income mothers, Black mothers, never-married mothers, mothers with less than a college education, and mothers under age 30 are least likely to receive the child support due under court order.[10]

Children Receiving Child Support

Child Support Enforcement in Rhode Island

◆ Families who receive state health insurance through the RIte Care program are encouraged to cooperate in establishing paternity, but a child may not be denied health benefits for failure to do so.

◆ Rhode Island has an in-hospital paternity establishment program at all birthing hospitals in the state. Hospital staff have been trained to obtain paternity acknowledgment from fathers while the newborn is in the hospital. Voluntary acknowledgment of paternity may also be established after the child leaves the hospital.[11]

◆ The state may revoke the driver's license of a parent who does not pay child support and may use liens and levies against property of delinquent parents.[12]

◆ Many non-custodial parents are poor themselves and lack a high school diploma and job experience.[13] Child support payments are more likely when enforcement strategies are combined with job training, job retention support, and transportation assistance for the non-custodial parent.[14]

◆ Under the Family Independence Act of 1996, Rhode Island Family Court judges may refer non-custodial fathers to education and training activities.[15]

Child Support and the Family Independence Program

◆ In order to receive cash benefits through the Family Independence Program (FIP), custodial parents are required to cooperate with the Rhode Island Department of Administration's Child Support Enforcement Division in establishing paternity and seeking child support.

◆ In certain instances, such as where there has been domestic violence, the requirement to establish paternity and seek child support may be waived in order to protect the custodial parent. Caseworkers are required to notify FIP applicants and recipients of this waiver option.[16]

◆ In 1999 in Rhode Island, 85% (28,415) of the 33,246 children enrolled in the Family Independence Program were in the Child Support Enforcement System. Of these, two-thirds have paternity established.[17]

◆ The average child support obligation to children enrolled in FIP is $207 per month, as compared to an average child support obligation of $237 per month for non-FIP families.[18]

◆ Rhode Island has maintained a $50 pass-through for families in the Family Independence Program.[19] The first $50 of child support paid on behalf of a child receiving cash assistance goes to the custodial parent caring for the child.[20] The pass-through occurs only if child support payments are received on-time and in-full.

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Children in Poverty

DEFINITION

Children in poverty is the percentage of related children under age 18 who live in families below the poverty threshold, as defined by the U.S. Office of Management and Budget. "Related children" include the family head's children by birth, marriage, and adoption, as well as other persons under age 18 who are related to and live with the family head, such as nieces and nephews.

SIGNIFICANCE

Children most at risk of not achieving their full potential are children in poverty, regardless of race.[1] Poverty is related to every KIDS COUNT indicator. Children who grow up in poor families are more likely to go without necessary food and clothing, to lack basic health care, live in substandard housing, and have unequal access to educational opportunities.[2] Children in low income communities are more likely to attend schools with outdated instructional materials and inadequate classroom facilities; have less access to libraries, museums, and cultural activities; have limited access to high quality child care programs; and have fewer opportunities to participate in sports, recreation, and enrichment programs after school and in the summer.[3,4]

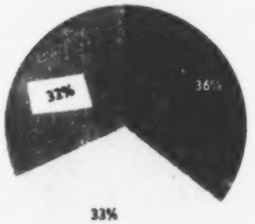
Single parenthood, low educational attainment, part-time or no employment, and low wages place children at risk of being poor.[5] Family economic conditions in early and middle childhood appear to be more important for shaping ability and achievement than do economic conditions during adolescence.[6] Efforts that improve the quality of a child's environment, especially in the early years of life, can produce lifelong impacts on learning, social skills, and mental health.[7]

Over time, many more people are poor than the official poverty line suggests. There is considerable movement into and out of poverty each year.[8] Those living with incomes close to the poverty line are vulnerable to falling into poverty due to changes in employment, housing and utility costs, life changes such as the birth of a child, changes in marital status, and illness or disability.[9] In 1999, the official poverty level for a family of four was $16,700. This is less than half the median family income for Rhode Island families with children.[10]

Rhode Island's Poor Children, 1997

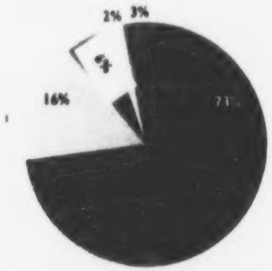
By Age

36%	■	Ages 5 and younger
33%		Ages 6 to 11
32%	▨	Ages 12 to 17



By Race*

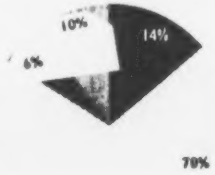
73%	■	White
16%		Black
6%	■	Asian
2%		Native American
3%	▨	Other



Hispanic children may be included in any race category. Of Rhode Island's 39,140 poor children, 26% are Hispanic.

By Family Structure

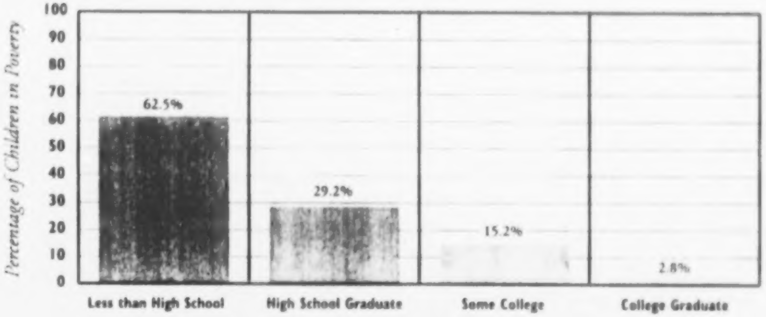
14%	■	Two Parents
70%		Mother Only
6%	■	Father Only
10%		Other



◆ **In 1997, there were 39,140 poor children in Rhode Island, 18% of all Rhode Island children. This is an increase from the 1990 Census figure when 14% of children lived in poverty.**

Source: U.S. Bureau of the Census, Current Population Survey, 1995-1999 average.

Young Children Under Age 6 in Poverty, by Educational Level of More Educated Parent, United States, 1997



Note: Percentages are calculated within each educational level.

- In 1997, almost two-thirds (62.5%) of young children whose parents did not graduate from high school were poor. Almost one-third (29.2%) of young children whose parents did not undertake education beyond a high school diploma were poor.

- The poverty rate in 1997 among children under age 6 whose better-educated parent attended some college was 15.2%, and declined to 2.8% for those who completed college.

- Between 1975 and 1997, the poverty rate for college educated parents remained low at 3%, while the poverty rate among young children of parents with less than a high school diploma increased by 31%.

Source: National Center for Children in Poverty (June 1999). *Young Children in Poverty: A Statistical Update.* New York: Columbia University, Joseph L. Mailman School of Public Health.

Young Children in Poverty, Rhode Island, 1997

- In 1997, 36% of Rhode Island's poor children were under age 6. One in five Rhode Island children under age 6 was living in poverty.[11]

- As of December 1, 1999, there were 13,337 young children under age 6 in families receiving cash assistance from the Rhode Island Family Independence Program. Of all children in the Family Independence Program, 40% are under age 6.[12]

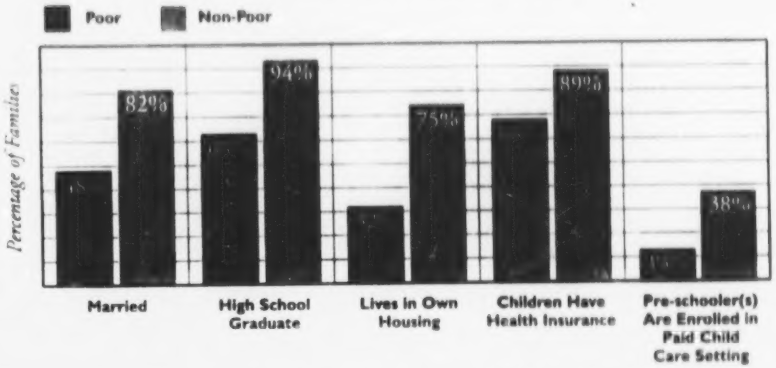
- Research shows that the quality of a child's environment and social interactions in the early years affect brain development, producing lifelong impacts on learning, social skills, and mental health.[13]

- Young children born into poverty are more likely to...
  be born low birthweight;
  die in infancy or early childhood;
  be hospitalized during childhood;
  receive lower quality medical care;
  experience hunger and malnutrition;
  be victims of or witnesses to violence;
  be exposed to environmental toxins.[14]

School-Age Children in Low-Income Families

- Between 1990 and 1999, the percentage of Rhode Island students ages 5 to 18 living in families with income below 185% of the federal poverty level increased from 23% (31,719) of all students to 35% (51,147) of all students.[15]

Selected Characteristics of Working Families, Poor and Non-Poor, United States, 1996



Source: Child Trends (1999). "Working Poor Families with Children: A Statistical Portrait," *Research Brief*. Washington, DC: Child Trends, Inc. Based on data from March 1997 Current Population Survey and 1993 panel of the Survey of Income and Program Participation.

Working Poor Families in Rhode Island

◆ In 1996, 55% of Rhode Island families with incomes below the poverty line worked full or part-time, up from 41% in 1993.[16] Almost one-third of all Rhode Island children (32%) lived in families in which neither parent was employed full-time year-round. Without secure parental employment, children are at increased risk of poverty.[17]

◆ Factors related to poverty among working families include single parenthood, low educational attainment, the predominance of jobs that pay lower wages, the inability to find full-time year-round work with benefits, transportation barriers, and unstable or unavailable child care.[18]

Building Blocks of Economic Security

◆ Educational Attainment

Individuals with higher education generally have more job opportunities, higher wages, and greater job security than those with lower levels of education.[19]

◆ High Quality Child Care

The quality and stability of the child care setting is critical to a parent's ability to work and to the child's development.[20]

◆ Affordable Housing

Stable housing is a critical requirement for job retention and performance. Low-income adults with unstable housing situations are less likely to find and keep a job.[21]

Family Income Levels Based on the Federal Poverty Line

The federal poverty line does not account for the costs of child care, health care, and housing. Many government assistance programs now use 185% to 250% of the federal poverty line (rather than 100% of the poverty line) to determine income eligibility. These figures are adjusted upward for larger family sizes.

1999 Federal Poverty Level (FPL)	Annual Income Family of Three	Annual Income Family of Four
100% FPL	$13,880	$16,700
130% FPL	$18,044	$21,710
185% FPL	$25,678	$30,895
200% FPL	$27,760	$33,400
225% FPL	$31,230	$37,575
250% FPL	$34,700	$41,750

Table 5.

Child Poverty, Rhode Island, 1990

	FAMILIES WITH CHILDREN BELOW POVERTY		CHILDREN UNDER 18 BELOW POVERTY		CHILDREN UNDER 6 BELOW POVERTY	
CITY/TOWN	**N**	**%**	**N**	**%**	**N**	**%**
Barrington	27	1.3%	52	1.3%	33	2.6%
Bristol	108	4.5%	253	5.9%	128	8.3%
Burrillville	148	6.3%	276	6.1%	119	8.5%
Central Falls	710	28.5%	1,576	32.5%	749	38.0%
Charlestown	68	7.8%	145	9.4%	39	6.4%
Coventry	199	4.7%	402	5.3%	180	7.3%
Cranston	735	8.9%	1,378	9.5%	562	10.9%
Cumberland	145	4.0%	302	4.7%	151	7.4%
East Greenwich	75	4.6%	153	5.3%	112	13.0%
East Providence	499	8.0%	904	8.7%	355	9.9%
Exeter	26	3.3%	52	3.6%	5	1.0%
Foster	34	5.5%	88	7.6%	0	0.0%
Glocester	99	7.2%	156	6.5%	77	10.0%
Hopkinton	40	4.1%	75	4.1%	9	1.4%
Jamestown	59	8.9%	92	8.1%	45	11.9%
Johnston	266	9.0%	452	8.4%	187	10.6%
Lincoln	164	7.2%	272	7.0%	98	7.2%
Little Compton	12	2.6%	20	2.7%	15	5.1%
Middletown	129	5.1%	275	6.0%	158	9.1%
Narragansett	71	4.4%	122	4.5%	36	3.6%
Newport	559	17.7%	1,143	20.3%	575	27.0%
New Shoreham	12	12.4%	17	10.1%	6	10.0%
North Kingstown	185	5.4%	281	4.7%	121	6.1%
North Providence	182	5.6%	298	5.4%	78	4.3%
North Smithfield	23	1.7%	37	1.6%	19	3.1%
Pawtucket	1,255	13.4%	2,525	15.5%	1,096	17.3%
Portsmouth	95	3.8%	182	4.4%	70	5.2%
Providence	5,621	29.2%	12,946	34.5%	5,531	36.8%
Richmond	9	1.1%	30	2.0%	0	0.0%
Scituate	45	3.3%	91	3.7%	19	2.3%
Smithfield	75	3.4%	155	4.1%	61	4.9%
South Kingstown	134	4.9%	350	7.5%	133	8.7%
Tiverton	109	6.0%	200	6.4%	81	7.9%
Warren	132	9.3%	199	8.5%	56	6.2%
Warwick	519	5.1%	1,084	5.9%	448	7.2%
Westerly	210	7.3%	432	8.7%	224	12.9%
West Greenwich	14	2.9%	26	2.9%	11	4.2%
West Warwick	395	10.7%	746	11.8%	291	13.0%
Woonsocket	1,183	20.0%	2,235	21.4%	1,034	26.9%
Core Cities	***9,328***	***23.2%***	***20,425***	***27.3%***	***8,985***	***30.7%***
Remainder of State	***5,043***	***6.0%***	***9,597***	***6.5%***	***3,927***	***7.9%***
Rhode Island	***14,371***	***11.6%***	***30,022***	***13.5%***	***12,912***	***16.3%***

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is all children under age 18 according to the 1990 Census of Population.

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Children in the Family Independence Program

DEFINITION

Children enrolled in the Family Independence Program is the percentage of children less than age 18 who were living in families receiving cash assistance through the Family Independence Program (FIP) on December 1, 1999. These data measure the number of children and families enrolled in FIP at one point in time. They do not count the additional children and families who qualified for the program at other points in the year but were not enrolled on December 1, 1999.

SIGNIFICANCE

Rhode Island's Family Independence Program seeks to help families make successful transitions to work by providing the supports, including health insurance and subsidized child care, that families need to obtain and keep a job. The Family Independence Program allows two-parent and single-parent families to obtain cash assistance. While cash benefits alone do not lift families out of poverty, they provide a minimal subsistence for poor families who can not work. The program improves work incentives by allowing working recipients to keep more of their earnings before cash assistance is decreased or terminated.

Through FIP, children in families that are income-eligible are entitled to cash assistance without time limits. A five-year time limit for cash benefits is placed on adults in the family. If a family has no earned income, the maximum monthly FIP benefit for a Rhode Island family of three is $554 per month.[1] With an additional $329 per month in Food Stamps, the monthly combined benefit is $883. This amount is 76% of the federal poverty level. When combined with earned income and the earned income tax credit, cash assistance can move a family working full-time at minimum wage above the poverty line of $13,880 for a family of three. As of December, 1999 in Rhode Island, 27% of the 16,209 adults receiving FIP cash assistance were employed.[2] The average wage for employed FIP recipients is $6.82 per hour.

More than two-thirds of all FIP beneficiaries are children under the age of 18. More than 80% of all children receiving cash assistance through FIP are ages 12 and under. As of December 1, 1999, there were 33,256 Rhode Island children in families receiving cash assistance through the Family Independence Program.[3] In the core cities as a whole (Providence, Pawtucket, Central Falls, Woonsocket and Newport), 34% of children live in families that receive cash assistance through FIP compared to 5% of children in the remainder of the state.[4]

Elements of Effective Welfare Reform

Assists families in obtaining sustainable jobs that move them out of poverty and into economic security.

◆ Low-income families require adequate income to meet their needs for housing, food, clothing, health insurance, child care, and transportation. Entry into sustainable jobs at a sufficient wage requires assistance with job placement, job training, English-language programs, literacy programs, vocational education, and post-secondary education.[5]

Supports the healthy development of children.

◆ Welfare reforms that increase family income, improve access to health care for children and families, and ensure that children have access to affordable, high-quality child care are likely to have positive impacts on child well-being.[6,7]

◆ In Rhode Island, full or partial child care subsidies are available for FIP recipients and for low-income working families up to 225% of poverty. Health insurance through RIte Care, Rhode Island's Medicaid managed care program, is available to all FIP recipients, to parents of eligible children in families with incomes up to 185% of poverty, and to all children under age 19 up to 250% of poverty.

Provides access to a range of supports needed by low-income families.

◆ It is the combination of benefits and support systems that is most likely to lift families out of poverty and enhance the well-being of children.[8] Families need information and help in accessing the variety of benefit programs that are available to them, including cash assistance through the Family Independence Program, food assistance (Food Stamps, WIC, School Lunch and School Breakfast), RIte Care health insurance, subsidized child care, Earned Income Tax Credit, and child support collection.[9,10]

◆ Some families will need a variety of social supports and social services in order to successfully transition from welfare to work. Comprehensive programs help parents find and keep employment, address the health and development needs of their children, strengthen parent-child relationships, and assist families with individual challenges. Many families will need assistance with child care, housing, transportation, substance abuse, domestic violence, or other issues.[11,12]

Children in the Family Independence Program

The Rhode Island Family Independence Program

Under the federal welfare reform law that replaced AFDC with the Temporary Assistance for Needy Families program (TANF), states are allowed to develop their own support programs for needy families. The Family Independence Program is Rhode Island's welfare reform program as set forth in the Rhode Island Family Independence Act of 1996.

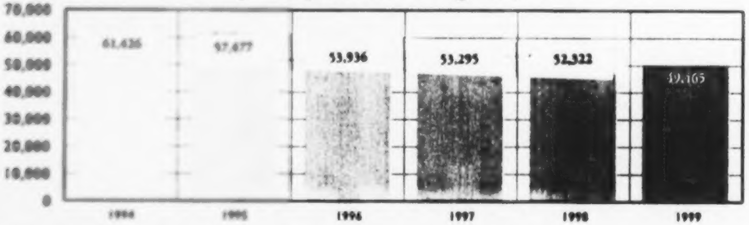
◆ One and two parent families are eligible for cash assistance if they meet the income eligibility guidelines (approximately 110% to 115% of the poverty line). Working cash recipients can earn up to $170 monthly without a reduction in cash assistance amount. After the first $170, benefits are reduced $1 for every $2 earned.

◆ There is a five-year time limit on receipt of cash assistance by adults unless they work at least 30 hours per week or receive an exemption from the work requirement. Cash assistance to eligible children is without time limits. Eligible teen parents under age 18 must live at home or in a supervised setting and stay in school.

◆ Unless exempt from the work requirements, adult recipients must develop an employment plan with a FIP social worker. Of the 11,028 adult recipients who need employment plans, 10,890 had a signed employment plan as of December 1999. The employment plan identifies the training, education, work readiness, or work in which the recipient will participate.

◆ There are approximately 3,800 adults who are exempt from the work requirement for one or more of the following reasons: child under age one (1,993), third trimester pregnancy (430), head of household under age 20 (359), illness or incapacity (315), illness or incapacity of a spouse or child (47), head of household 60 or over (35), other (679).

Adults and Children Enrolled in AFDC/Family Independence Program, 1994 to 1999



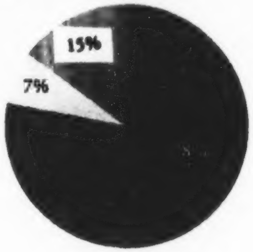
Source: Rhode Island Department of Human Services, INRHODES Database, 1994 to 1999.

Note: Prior to May 1, 1997, the Family Independence Program was AFDC (Aid to Families with Dependent Children)

Families Enrolled in the Family Independence Program, December 1999

By Family Type

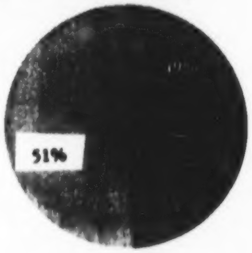
78%	■	Single Parents
7%		Two-Parents
15%	▨	Child Only



n = 17,473

By Participation in Work/ Education/Training

49%	■	Participating
51%	▨	Not Participating

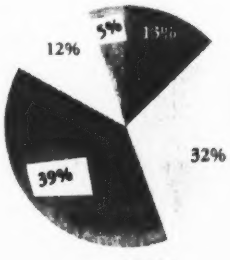


n = 11,028

(Includes all adults with work, work preparation, education requirements)

By Education Level of Household Head

13%	■	Less than 9th grade
32%		Grades 9 to 11
39%	▨	High School Graduate
12%		Some College or College Graduate
5%		Unknown

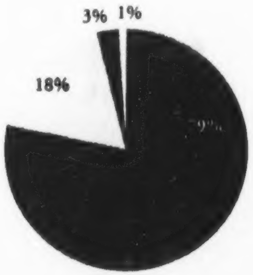


n = 14,884

(Does not include the 2,589 child only families)

By Primary Language

79%	■	English
18%		Spanish
3%	▨	Asian
1%		Other



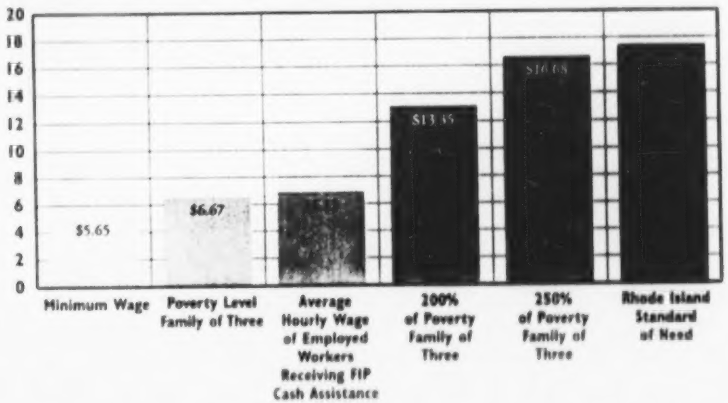
n = 17,473

"Asian" includes Vietnamese, Cambodian, Laotian, Hmong.
"Other" includes Portuguese, French, Polish, Italian, Hungarian, Russian.

Source: Rhode Island Department of Human Services, INRHODES Database, December 1999.

Children in the Family Independence Program

Wages Compared to the Standard of Need, Rhode Island, 1999



◆ For a single parent in Providence with one pre-school child and one school-age child, the hourly wage needed for self-sufficiency is $17.50 (termed the "standard of need"). In general, families whose income is below the "standard of need" lack the ability to secure their basic needs for food, shelter, health care, and child care at a minimally adequate level unless they have access to subsidies.

◆ Child care subsidies, because they substantially reduce the cost of what is the single most expensive need for many families, are a critical resource to families with incomes up to 250% of the federal poverty line.

◆ Public housing, food stamps, RIte Care, the FIP Earned Income Disregard, child care subsidies, and the Earned Income Tax Credit are important policies to ensure that low-income working families have adequate resources to meet their basic needs (including health care, child care, housing, and transportation).

Source: Poverty Institute at Rhode Island College (1999), using methodology for the Self-Sufficiency Standard developed by Diana M. Pearce, Ph.D., Swarthmore College and Wider Opportunities for Women, Inc.; and Diana M. Pearce, Ph.D. (March 1998). *When Wages Aren't Enough*. Philadelphia, PA: Pennsylvania Family Economic Self-Sufficiency Project and the Women's Association for Women's Alternatives, Inc.

Children in the Most Vulnerable Families

◆ As welfare reform approaches the fourth year of implementation, states are beginning to focus on the hardest to serve families. Adults with the most barriers to work (including poor social skills, low literacy skills, depression, mental or physical health problems, substance abuse, or domestic violence) have the most difficulty making the transition from welfare to work.

◆ Welfare research nationally indicates that the families most likely to face sanctions or reach time limits have children who are already at particularly high developmental risk. As welfare reform is implemented, it is crucial that these children receive assessments and early intervention for developmental issues, are enrolled in high quality child care, and have a regular source of health care.

◆ National research shows that recipients who had received welfare for two or more years were less likely to have work experience. They provided less cognitive and emotional stimulation to their children and their children had low scores on measures of receptive vocabulary and social maturity.

◆ Welfare recipients who have received benefits for five or more years report more depressive symptoms and lower levels of social support than short-term recipients (less than two years).

◆ Welfare research nationally indicates that families receiving sanctions (i.e. losing cash benefits for non-compliance with program guidelines) are more likely to have prior contacts with child welfare agencies or protective services. Therefore, there is reason to be concerned about the development of children in these very disadvantaged families.

Source: Research Forum on Children, Families, and the New Federalism (July 1999). *Children in Fragile Families Face Multiple Risks under Welfare Reform*. New York, NY: National Center for Children in Poverty, Columbia University School of Public Health.

Children in the Family Independence Program

Table 6

Children Enrolled in the Family Independence Program (FIP), Rhode Island, December 1999

CITY/TOWN	ESTIMATED 1999 CHILDREN UNDER 18	NUMBER RECEIVING FIP CASH ASSISTANCE FAMILIES	CHILDREN	FIP CHILDREN AS % OF ALL CHILDREN UNDER 18
Barrington	3,896	20	28	0.7%
Bristol	4,317	140	238	5.5%
Burrillville	4,215	72	143	3.4%
Central Falls	4,603	891	1,784	38.8%
Charlestown	1,795	47	74	4.1%
Coventry	7,682	205	296	3.9%
Cranston	14,079	824	1,323	9.4%
Cumberland	6,338	123	197	3.1%
East Greenwich	2,653	54	91	3.4%
East Providence	10,351	538	901	8.7%
Exeter	1,672	17	24	1.4%
Foster	1,175	16	28	2.4%
Glocester	2,257	32	53	2.3%
Hopkinton	2,035	41	62	3.0%
Jamestown	1,228	13	18	1.5%
Johnston	5,294	295	487	9.2%
Lincoln	3,918	100	170	4.3%
Little Compton	701	8	11	1.6%
Middletown	4,487	64	102	2.3%
Narragansett	3,206	89	154	4.8%
Newport	5,437	479	966	17.8%
New Shoreham	178	2	3	1.7%
North Kingstown	6,809	173	286	4.2%
North Providence	5,641	325	512	9.1%
North Smithfield	2,088	29	50	2.4%
Pawtucket	16,093	1,938	3,621	22.5%
Portsmouth	4,387	41	65	1.5%
Providence	37,195	7,760	16,003	43.0%
Richmond	1,610	40	66	4.1%
Scituate	2,635	30	39	1.5%
Smithfield	3,958	42	58	1.5%
South Kingstown	5,152	115	200	3.9%
Tiverton	2,988	65	95	3.2%
Warren	2,487	105	192	7.7%
Warwick	18,811	692	1,142	6.1%
Westerly	5,666	207	370	6.5%
West Greenwich	1,147	16	31	2.7%
West Warwick	6,696	435	737	11.0%
Woonsocket	10,101	1,356	2,636	26.1%
Core Cities	***73,429***	***12,424***	***25,010***	***34.1%***
Remainder of State	***151,552***	***5,015***	***8,246***	***5.4%***
Rhode Island	***224,981***	***17,439***	***33,256***	***14.8%***

Source of Data for Tables/Methodology

Rhode Island Department of Human Services, INRHODES Database, December 1, 1999.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is the total number of children under age 18 in 1999 according to GeoLytics estimates using data from the U.S. Bureau of the Census, 1990 Census of Population.

See methodology on page 96 for additional information on GeoLytics estimates.

References for Indicator

[1,3] Rhode Island Department of Human Services, INRHODES Database, December 1, 1999.

[4] Rhode Island Department of Human Services, INRHODES Database, December 1, 1999. Calculations by Rhode Island KIDS COUNT.

[5,10] *Windows of Opportunity: Strategies to Support Families Receiving Welfare and Other Low-Income Families in the Next Stage of Welfare Reform* (January 2000). Washington, DC: Center on Budget and Policy Priorities.

[6] Collins, A., Jones, S., Bloom, H. (1996). *Children and Welfare Reform: Highlights from Recent Research.* New York: National Center for Children in Poverty, Columbia University School of Public Health.

[11] Cauthen, N.K., Knitzer, J. (1999). *Children and Welfare Reform, Issue Brief #6. Beyond Work: Strategies to Promote the Well-Being of Young Children and Their Families.* New York, NY: National Center for Children in Poverty.

[8] *The Safety Net Delivers: The Effects of Government Benefits Programs in Reducing Poverty* (1999). Washington, DC: Center on Budget and Policy Priorities.

[7] Loprest, P. (1999). *Families Who Left Welfare: Who are They and How are They Doing?* Washington, DC: Urban Institute.

[9] *Meeting the Challenges of Welfare Reform: Programs with Promise* (1998). Denver, CO: National Conference of State Legislatures.

Children Receiving Food Stamps

DEFINITION

Children receiving food stamps is the percentage of income-eligible children under age 18 who participate in the Food Stamp program.

SIGNIFICANCE

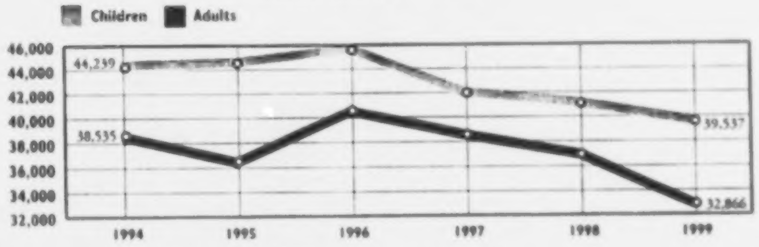
The Food Stamp program provides monthly benefits that can be used for the purchase of food at retail stores. Research shows that participation in the Food Stamp program increases a family's ability to purchase an adequate low-cost diet and helps low-income households achieve better nutritional intake.[1,2] The Food Stamp program provides important nutrition benefits to low-income families, single adults without children, and the elderly who would otherwise be at high risk for undernutrition and poor health.[3]

To qualify for food stamps, a household's gross income must be less than 130% of the poverty level for that family size and meet requirements that limit the value of assets (such as cash and automobiles). For example, a family of four with an annual income less than $21,710 (monthly income less than $1,809) will qualify for Food Stamps if they meet the assets guidelines. Many of Rhode Island's legal immigrants qualify for food stamp benefits. Rhode Island is one of 17 states that has state-funded food stamps for some legal immigrants who are no longer eligible for federally-funded food stamps.[4]

The Food Stamp program is an entitlement, meaning that federal funding is provided to all applicants who meet the eligibility requirements. One of the strengths of the Food Stamp program is its ability to respond to changes in the state's economy.[5] The benefit level for each eligible household is adjusted according to income. The monthly benefit level decreases as household income increases.

The maximum monthly Food Stamp benefit for a family of three is $329. The average monthly benefit for a family of three in Rhode Island is $203, a decrease from the 1997 monthly average of $270.[6] As of December 1, 1999 there were 72,403 individuals in Rhode Island who received benefits from the Food Stamp program; of these, 39,537 were children. More than half (55%) of all food stamp recipients in Rhode Island are children under age 18.[7] Nationally households with children receive 80% of all food stamp benefits.[8]

Food Stamp Participation, Children under Age 18 and Adults, Rhode Island, 1994-1999



Source: RI Department of Human Services, INRHODES Databases, 1994-1999

◆ Between 1994 and 1999, participation in the Food Stamp program decreased by 15% for Rhode Island adults and by 11% for Rhode Island children. It is estimated that only half (52%) of all Rhode Island children eligible for the Food Stamp program are enrolled.[9]

◆ National studies indicate that only a portion of the declines in Food Stamp program participation in recent years can be attributed to the strong economy and low unemployment rates. Other factors include: lack of information about program eligibility, lack of knowledge that working families can receive benefits, families losing Food Stamp benefits when they transition from welfare to work, and the limitation on the asset value of a car (which limits participation by working poor families that require a reliable vehicle to maintain their job).[10]

◆ Two-parent and single-parent working families can qualify for Food Stamps if they meet the limits for income and assets. A family does not need to be eligible for, or receiving assistance through, the Family Independence Program (FIP) to qualify for food stamps.[11]

◆ The federal welfare law requires that states develop adequate procedures to ensure that families that are denied, diverted from, or terminated from the Family Independence Program are fully considered for food stamp benefits for which they qualify. Most families enrolled in FIP whose earnings cause them to become ineligible for cash assistance continue to have earnings sufficiently low that they still qualify for food stamp benefits.[12]

◆ Food stamp outreach programs can counteract barriers to enrollment by providing information on the Food Stamp program to low-income working families; by training state and local human service providers on program regulations; and by providing application assistance to eligible households in need of food stamps.[13]

Children Receiving Food Stamps

Table 7. **Children Under Age 18 Receiving Food Stamps, Rhode Island, December 1, 1999**

CITY/TOWN	ESTIMATED NUMBER ELIGIBLE	NUMBER PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	48	34	71%
Bristol	NA	292	NA
Burrillville	466	192	41%
Central Falls	5,298	2,187	41%
Charlestown	NA	99	NA
Coventry	738	322	44%
Cranston	2,472	1,573	64%
Cumberland	609	266	44%
East Greenwich	115	104	90%
East Providence	2,691	1,107	41%
Exeter	NA	26	NA
Foster	107	36	34%
Glocester	299	80	27%
Hopkinton	NA	107	NA
Jamestown	54	24	44%
Johnston	878	574	65%
Lincoln	377	253	67%
Little Compton	40	21	52%
Middletown	671	157	23%
Narragansett	308	168	55%
Newport	2,585	1,209	47%
New Shoreham	17	3	18%
North Kingstown	540	326	60%
North Providence	1,036	592	57%
North Smithfield	132	48	36%
Pawtucket	9,826	4,373	45%
Portsmouth	179	108	60%
Providence	34,668	18,721	54%
Richmond	NA	94	NA
Scituate	145	44	30%
Smithfield	174	94	54%
South Kingstown	424	211	50%
Tiverton	266	103	39%
Warren	NA	242	NA
Warwick	2,421	1,315	54%
Westerly	722	473	66%
West Greenwich	NA	34	NA
West Warwick	2,031	870	43%
Woonsocket	5,687	3,055	54%
Core Cities	***58,784***	***29,545***	***50%***
Remainder of State	***18,918***	***9,992***	***53%***
Rhode Island	***75,403***	***39,537***	***52%***

Source of Data for Table/Methodology

Estimated number eligible is based on the total number of children ages birth to 18 (projections from the 1990 Census) multiplied by the % of students eligible for free School Lunch in each community. Families with incomes less than 130% of poverty are income-eligible for free School Lunch and for Food Stamps (the Food Stamp program also has an assets limitation as part of eligibility determination). Free lunch percentages are from the Rhode Island Department of Education, October 1999.

NA: Numbers are not available as community has a regional school district.

Food Stamp program participation data are from the RI Department of Human Services, INRHODES, December 1, 1999. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

References for Indicator

[1,5] *Statement on the Link between Nutrition and Cognitive Development in Children* (1998). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[2] Devaney, B.L., Ellwood, M.R., Love, J.M. "Programs that Mitigate the Effects of Poverty on Children" in *The Future of Children: Children and Poverty*, Vol 7, No.2 (Summer/Fall 1997). Los Altos, CA: The David and Lucile Packard Foundation.

[3] Cook, J.T. (May 1998). "The Importance of the Food Stamp Program for Low-Income Legal Immigrants." Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[4] "New Federal Food Stamp Restoration for Legal Immigrants" (July 10, 1998). Washington, DC: Center on Budget and Policy Priorities.

[6,7] Rhode Island Department of Human Services, INRHODES Database, December 1, 1994-1999. Calculations by Rhode Island KIDS COUNT.

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Children Receiving School Breakfast

DEFINITION

Children receiving school breakfast is the percentage of low-income public school children who attend schools offering the School Breakfast Program. Half-day kindergarten, private schools, and residential child care facilities are not included in the calculations. Children are counted as low-income if they are eligible for and enrolled in free or reduced price lunch.

SIGNIFICANCE

Undernutrition during any period of childhood can have a detrimental impact on a child's cognitive development. The longer a child's nutritional needs go unmet, the greater the risk of cognitive impairment.[1] Low-income students are more likely than other students to arrive at school without an adequate breakfast.[2] The School Breakfast Program offers nutritious meals to children at participating schools, providing children with one-fourth or more of their Recommended Daily Allowance for key nutrients.[3]

Federal and state funds are available to support the costs of the School Breakfast Program. Of the 317 public schools in Rhode Island, three-quarters (229 schools) offer the School Breakfast Program. To receive a reduced-price meal, household income must be below 185% of the federal poverty level. For free meals, household income must fall below 130% of poverty. Children in Food Stamp and Family Independence Program households are automatically eligible for free meals. Children who participate in the School Breakfast Program have better school attendance, are more likely to arrive at school on time, and have higher standardized test scores than non-participants.[4]

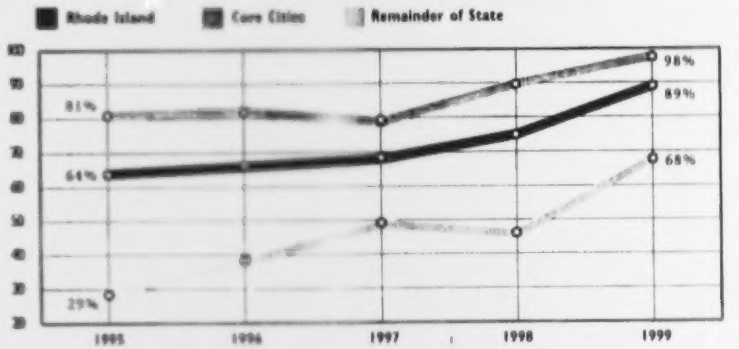
Percentage of Low-Income Students Attending Schools that Offer the School Breakfast Program, Selected School Districts, 1995 and 1999

	1995	1999
Burrillville	100%	100%
Central Falls	100%	100%
Providence	100%	100%
West Warwick	29%	100%
Pawtucket	21%	100%
Newport	17%	100%
Foster	0%	100%
South Kingstown	0%	100%
Tiverton	0%	100%
Rhode Island	64%	89%

◆ **In the 1999-2000 school year, nine of Rhode Island's thirty-six school districts offered the School Breakfast Program to all low-income students in their district.**

Source: Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, 1995 and 1999. Calculations by Rhode Island KIDS COUNT

Percentage of Low-Income Children Attending Schools that Offer the School Breakfast Program, Rhode Island and Core Cities, 1995 to 1999



◆ The percentage of low-income students attending schools offering the School Breakfast Program has increased from 64% in the Fall of 1995 to 89% in the Fall of 1999. The core cities offer the breakfast program to 98% of low-income students, an increase from 81% in 1995. The remainder of the state offers the breakfast program to 68% of low-income students, an increase from 29% in 1995.

◆ In 1999 the Rhode Island General Assembly expanded the mandatory school breakfast law to include all elementary, middle, and high schools in which 20% or more of the students are eligible for free or reduced priced lunches. The original version of the law, passed in 1998, had included only elementary schools with 40% or more low-income students. Twenty-three states have laws mandating the provision of the School Breakfast Program.[5]

◆ The number of low-income students in schools that do not offer the School Breakfast Program decreased from 16,905 in 1995 to 5,841 in 1999. Of the 317 Rhode Island public schools, 88 (28%) do not offer the breakfast program. In 1995, almost two-thirds (62%) of Rhode Island public schools did not offer the breakfast program.

Source: Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, 1995-1999. Calculations by Rhode Island KIDS COUNT

Children Receiving School Breakfast

Table 8.

Low-Income Children Receiving School Breakfast, Rhode Island, Fall 1999

SCHOOL DISTRICT	NUMBER OF LOW-INCOME STUDENTS IN DISTRICT	NUMBER OF LOW-INCOME STUDENTS ATTENDING SCHOOLS WITH BREAKFAST	PERCENT OF LOW-INCOME STUDENTS ATTENDING SCHOOLS WITH BREAKFAST	TOTAL NUMBER OF SCHOOLS IN DISTRICT	NUMBER OF SCHOOLS ≥ 20% FREE/REDUCED PRICE LUNCH
Barrington	62	0	0%	6	0
Bristol-Warren	1,012	822	81%	11	7
Burrillville	457	457	100%	5	2
Central Falls	3,366	3,366	100%	7	8
Chariho	476	387	81%	6	0
Coventry	799	758	95%	9	3
Cranston	2,015	1,592	79%	23	13
Cumberland	588	506	86%	9	3
East Greenwich	125	90	72%	6	0
East Providence	2,020	1,121	55%	15	13
Exeter-W. Greenwich	248	109	44%	4	0
Foster	49	49	100%	1	0
Foster-Glocester	133	0	0%	2	0
Glocester	126	0	0%	2	0
Jamestown	36	0	0%	2	0
Johnston	595	429	72%	8	5
Lincoln	356	167	47%	7	1
Little Compton	34	0	0%	1	0
Middletown	546	477	87%	6	4
Narragansett	230	0	0%	3	0
Newport	1,335	1,335	100%	9	9
New Shoreham	12	0	0%	1	0
North Kingstown	548	202	37%	10	2
North Providence	668	283	42%	9	6
North Smithfield	169	0	0%	4	6
Pawtucket	5,741	5,741	100%	16	16
Portsmouth	173	0	0%	6	1
Providence	20,647	20,647	100%	51	51
Scituate	158	0	0%	5	0
Smithfield	174	45	26%	6	0
South Kingstown	455	455	100%	8	2
Tiverton	307	307	100%	6	1
Warwick	2,045	1,190	58%	26	12
Westerly	578	535	93%	7	4
West Warwick	1,196	1,196	100%	6	5
Woonsocket	3,668	3,040	83%	14	14
Core Cities	***34,757***	***34,129***	***98%***	***97***	***98***
Remainder of State	***16,390***	***11,177***	***68%***	***220***	***90***
Rhode Island	***51,147***	***45,306***	***89%***	***317***	***188***

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, Fall 1999. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Number of low-income students is the number of students eligible for and enrolled in free or reduced price lunches in the Fall of 1999. Low-income students receiving breakfast is the percent of students enrolled in free or reduced priced lunches who attend schools serving breakfast in the Fall of 1999. Half-day kindergarten, private schools and residential child care facilities may offer the School Breakfast Program, but are not included in these calculations.

The denominator is the number of children enrolled in the public school who are eligible for and enrolled in free or reduced price lunches in the Fall of 1999, not including half-day kindergarten.

References for Indicator

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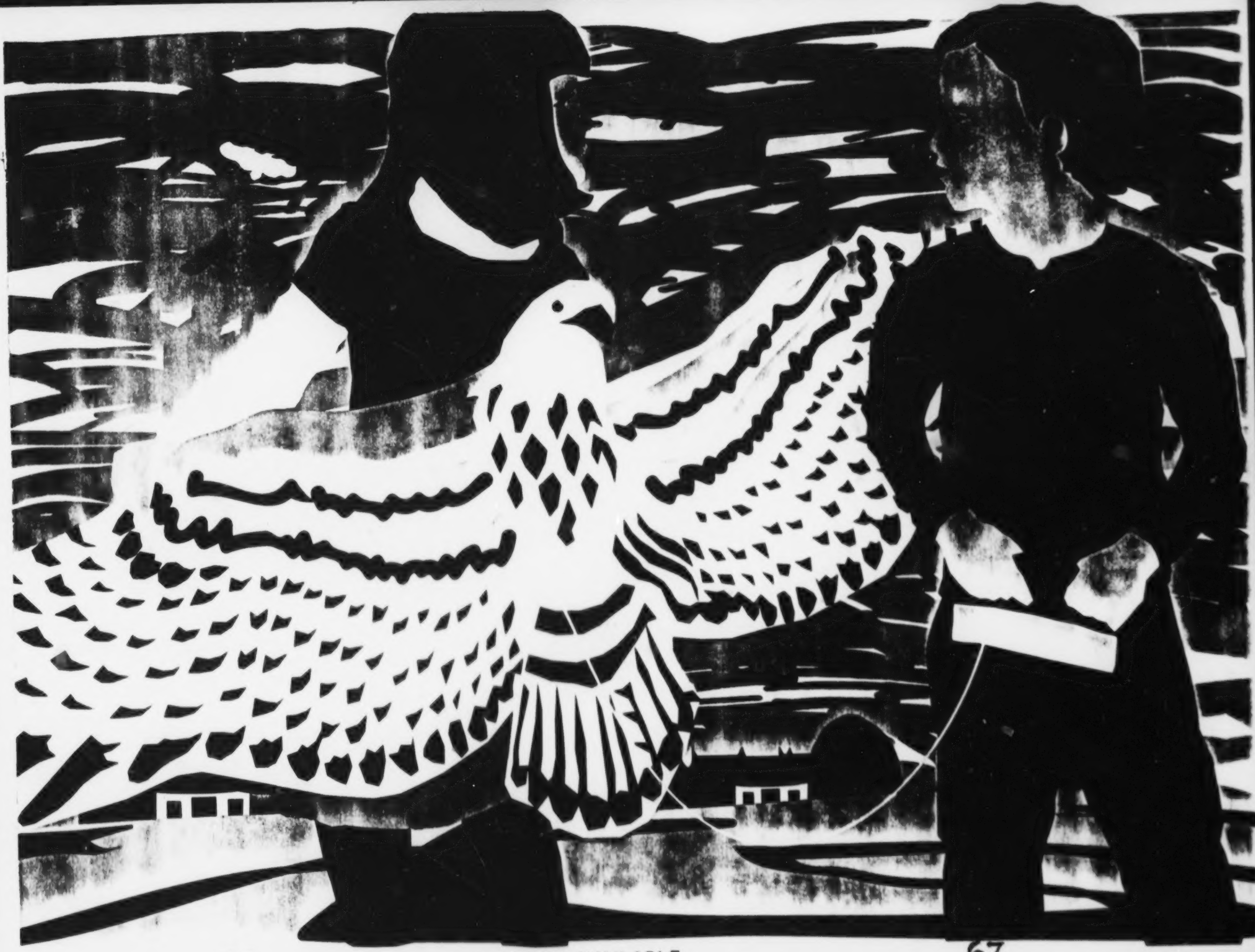
Health

Oath of Friendship

Shang ya!
I want to be your friend
For ever and ever without break or decay.
When the hills are all flat
And the rivers are all dry,
When it lightens and thunders in winter,
When it rains and snows in summer,
When Heaven and Earth mingle–
Not till then will I part from you.

– Anonymous, China, 1st century B.C.



Children's Health Insurance

DEFINITION

Children's health insurance is the percentage of children under age 19 who were covered by any kind of public or private health insurance, including Medicaid, during the previous calendar year. These data reflect only those who were insured through the entire year and do not include those who were insured for only part of the year.

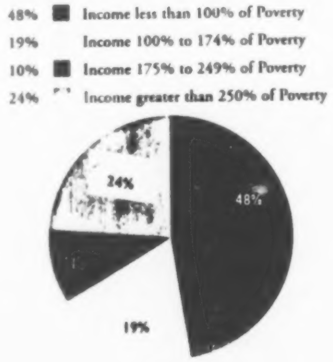
SIGNIFICANCE

Health care is vital to every child's growth and development. Lack of insurance coverage makes it difficult to obtain primary and specialty care – including preventive health care, comprehensive treatment for acute and chronic illness, mental health services, dental care, and prescriptions.[1] Undiagnosed and untreated medical conditions can result in long-term health problems and interfere with learning and development.[2]

Regular medical visits are especially critical during early childhood to receive immunizations and to be screened and treated for any developmental problems.[3] Insured children and teens are more likely to receive required preventive services, to have a relationship with a primary care physician, and to receive a physician's care for acute and chronic health problems, such as asthma.[4]

As of 1997, nine percent (21,000) of Rhode Island children under age 19 were uninsured.[5] Low family income and educational levels, lack of transportation, and language differences are barriers to obtaining health insurance and accessing health care services.[6,7] Working families often do not know that they qualify for public health insurance. Families are most likely to enroll in public health insurance programs if they are also applying for cash assistance. Efforts that ensure continuity of insurance coverage for families as they change jobs and/or transition from cash assistance programs are critical to reducing the rates of uninsured children.[8,9,10]

Children Under Age 19 without Health Insurance, by Poverty Level, Rhode Island, 1997



n = 21,000

Numbers may not add to 100 due to rounding

Source: U.S. Bureau of the Census, Current Population Survey, 1995-1999 average. Compiled by The Annie E. Casey Foundation.

RIte Care Health Insurance for Families

◆ RIte Care, Rhode Island's Medicaid managed care program, is available to the following groups:

Children under age 19 in families with income up to 250% of poverty.
Parents of eligible children, in families with income up to 185% of poverty.
Pregnant women up to 350% of poverty.
Families enrolled in the Family Independence Program.
Child care providers who serve low-income children.

◆ Of the 92,654 RIte Care members enrolled on December 1, 1999, more than two-thirds were children under age 19. As of December 1, 1999 there were 13,062 "low-income parents" enrolled in RIte Care. Low-income parents of eligible children can enroll in RIte Care if their family income is less than 185% of poverty.[11]

Uninsured Children in Rhode Island, 1997

◆ More than three-quarters of the uninsured children in Rhode Island live in families under 250% of the federal poverty level and are therefore eligible to enroll in RIte Care.[12]

◆ Almost half of Rhode Island's 21,000 uninsured children live in families with incomes below the federal poverty line of $13,880 for a family of three.[13] Nationally, poor children and Hispanic children are the most likely to be uninsured.[14]

◆ One in every four (24%) poor children in Rhode Island is uninsured, the highest rate among any income group. Thirteen percent of children in families with incomes between 100% and 200% of poverty are uninsured and 4% of children in families with incomes above 200% of poverty are uninsured.[15]

◆ Almost three-quarters (71%) of Rhode Island's uninsured children live in working families. Working families are most likely to be uninsured when their employer does not offer health insurance or the family cannot afford monthly payments for family health coverage.[16]

Table 9.

Children Under Age 19 Receiving Medical Assistance, Rhode Island, December 1999

CITY/TOWN	Rite Care FIP	Rite Care Non-FIP	SSI	Other	Total
Barrington	43	61	2	27	133
Bristol	273	311	12	12	608
Burrillville	159	334	14	15	522
Central Falls	1,976	1,343	118	6	3,443
Charlestown	91	153	10	3	257
Coventry	340	669	26	40	1,075
Cranston	1,512	1,581	91	89	3,273
Cumberland	230	406	19	33	688
East Greenwich	105	107	3	18	233
East Providence	994	1,149	59	39	2,241
Exeter	33	85	2	5	125
Foster	30	64	0	6	100
Glocester	69	171	6	6	252
Hopkinton	82	194	7	5	288
Jamestown	20	44	0	3	67
Johnston	527	571	38	15	1,151
Lincoln	196	334	19	20	569
Little Compton	13	45	1	2	61
Middletown	118	309	16	18	461
Narragansett	162	178	4	12	356
Newport	1,041	774	57	14	1,886
New Shoreham	5	16	1	0	22
North Kingstown	319	471	21	37	848
North Providence	556	599	31	20	1,206
North Smithfield	59	99	6	14	178
Pawtucket	3,951	2,878	273	62	7,164
Portsmouth	78	215	7	22	322
Providence	17,038	8,652	1,016	4,158	30,864
Richmond	75	101	24	23	223
Scituate	50	135	4	13	202
Smithfield	75	191	7	14	287
South Kingstown	249	332	25	27	633
Tiverton	97	251	9	7	364
Warren	222	219	9	6	456
Warwick	1,240	1,583	103	88	3,014
West Greenwich	32	91	5	5	133
West Warwick	830	884	43	25	1,782
Westerly	404	550	20	25	999
Woonsocket	2,870	1,714	188	28	4,800
Out-of-State	*0*	*0*	*40*	*0*	*40*
Unknown	*236*	*209*	*1,521*	*67*	*2,033*
Core Cities	*25,840*	*14,603*	*1,596*	*4,254*	*46,293*
Remainder of State	*10,560*	*13,470*	*2,221*	*775*	*27,026*
Rhode Island	*36,400*	*28,073*	*3,817*	*5,029*	*73,319*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, MMIS Database, December 1, 1999. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The column labeled "RIte Care/FIP" is the number of children enrolled in RIte Care as of December 1, 1999 who also participate in the Family Independence Program. "RIte Care, Non-FIP" includes all other RIte Care participants under the age of 19 and pregnant women. "SSI" is children enrolled in fee-for-service Medicaid because they receive SSI. "Other" includes foster children and non-SSI children with disabilities who are enrolled in fee-for-service Medicaid. The Providence numbers for "other" include foster children who may live in other towns, because the DHS database lists foster children as Providence residents for administrative purposes.

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Access to Dental Care

DEFINITION

Access to dental care is the percentage of children under age 18 who were covered by any kind of public or private dental insurance, including Medicaid, according to the 1996 Rhode Island Health Interview Survey.

SIGNIFICANCE

Children who receive an inadequate level of dental care or no dental care at all can develop long-term oral health problems and are more likely to experience dental conditions that require emergency treatment.[1] Preschool children with untreated dental caries are more likely to develop poor eating habits, to have difficulty socializing with peers, and to have speech problems. Children with poor dental health in the early childhood years are at increased risk for future dental caries in their permanent teeth.[2] In school-age children and adolescents, chronic dental problems can lead to poor self-image, lack of concentration, absenteeism, and reduced school performance.[3]

Children without dental insurance are less likely to get needed dental care. Children with no dental insurance are three times as likely as privately-insured children to be unable to get care when they need it.[4] For children in low-income families, the efficacy of public dental insurance is a critical factor in access to dental prevention and treatment.[5] Dental access barriers for children insured through RIte Care include difficulty finding a dental provider who will accept RIte Care coverage, lack of parental education on the need for prevention and treatment, and high no-show rates for dental appointments.[6,7]

Access to dental care is a major obstacle confronting children from poor, working poor, and uninsured families.[8] Children in families with incomes below poverty and minority children have the greatest extent of untreated dental problems.[9]

Access to dental specialists is difficult for children covered through public health insurance programs.[10] Children with disabilities may also have problems with access to providers equipped to address their special dental needs.[11]

In Rhode Island in 1996, families with education beyond high school were significantly more likely to have dental insurance coverage than those with less education.[12] In 1996, 31% of Rhode Island children under age 5 and 26% of children between ages 6 and 18 were uninsured for dental services.[13]

Dental Care for Low-Income Children: A National Problem

◆ Children from low-income families are at highest risk for tooth decay and have the greatest unmet treatment needs. The National Institute of Dental Research reports that 80% of tooth decay occurs in only 25% of U.S. children and adolescents.

◆ Fewer children visit a dentist before entering kindergarten today than ten years ago despite the increased awareness of the fact that tooth decay starts before age two. Nearly one-third of the cavities in children ages 6 to 8 have not been repaired.

◆ Among parents reporting their children's unmet health care needs, 57% reported unmet dental needs. Twice as many parents reported unmet needs for their children's dental treatment as compared to unmet needs for their children's medical care.

Source:Edelstein, B.L.(May 1998). "Crisis in Care: The Facts Behind Children's Lack of Access to Medicaid Dental Care" *NCEMCH Policy Brief.* Washington, DC: Georgetown University, National Center for Education in Maternal and Child Health.

Early Childhood Caries (Baby Bottle Tooth Decay)

◆ Early childhood caries is rampant decay in the primary teeth of infants and toddlers. It is caused by frequent and prolonged exposure of the teeth to carbohydrates, particularly sugar in juice, milk, or infant formula. This exposure is a result of putting a child to bed with a bottle containing sugary liquid, or allowing a child to drink from a bottle throughout the day.[14]

◆ Nationally, 5% to 10% of young children have early childhood caries. This rate is significantly higher among children from low-income families; 20% of children from low-income families have this condition.[15]

◆ Prevention of early childhood caries requires parent education regarding healthy child nutrition and oral hygiene, a first dental visit by 12 months of age, and ongoing preventive dental care and dental treatment.[16]

◆ Treatment of early childhood caries often requires extensive restorative work, stainless steel crowns, and tooth extraction. Dental health insurance increases the likelihood that needed treatment is provided.[17]

Access to Dental Care

Access to Dental Care: EPSDT and Medicaid

◆ All children enrolled in RIte Care are entitled to comprehensive dental services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Children are eligible to receive preventive dental care and dental treatment services.[18]

◆ States are required to recruit dentists to participate, locate eligible families and inform them about EPSDT services, and assure that providers perform the required services. Low reimbursement rates and the high no show rate among Medicaid recipients are significant barriers to provider participation.[19]

◆ In 1996, a national study indicated that fewer than one in five children enrolled in Medicaid and eligible for EPSDT actually received preventive dental services; fewer received needed treatment.[20]

◆ Nationally, children eligible for Medicaid experience twice the rate of untreated dental disease as more affluent children.

◆ States spend only one-tenth as much on dental care for Medicaid enrollees as the national average for all children.[21] In the U.S., 30% of all child health expenditures are for children's dental care; only 2.3% of all Medicaid child health expenditures are for children's dental care.[22]

Dental Services for RIte Care Members

◆ Dental services provided to RIte Care enrollees are paid for by Medicaid on a fee-for-service basis. Several regions of Rhode Island have limited providers serving RIte Care enrollees and few dental specialists participate in Medicaid fee-for-service.[23]

◆ Statewide, there are 113 RIte Care enrollees for each Medicaid fee-for-service dentist. This is an overestimate of dental access, because participating dentists may place severe limits on the number of Medicaid clients they will accept; some serve no Medicaid clients. In Woonsocket, Pawtucket, and Providence there are more than 220 RIte Care enrollees per dental provider. In Central Falls, there are over 1,000 RIte Care enrollees for every dental provider.[24]

◆ Five community health centers in the state provide dental care, and all have waiting lists for new patients. Community health centers represent less than 2 percent of dental providers listed as participating in the Medicaid program, yet they deliver approximately 20% of the dental visits to RIte Care members age 14 and under.[25]

◆ Dental screenings are available through Head Start, Donated Dental Services of Rhode Island (for children with disabilities), and Travelers Aid program for homeless teens. The Samuels Dental Center at Rhode Island Hospital provides pediatric dental services, including special services for children with disabilities. In Providence, expansions of the targeted school-based sealant program and the dental clinic at St. Joseph's Hospital have increased access for low-income and immigrant children.

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Women and Children Receiving WIC

DEFINITION

Women and children receiving WIC is the percentage of eligible women, infants and children served by the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

SIGNIFICANCE

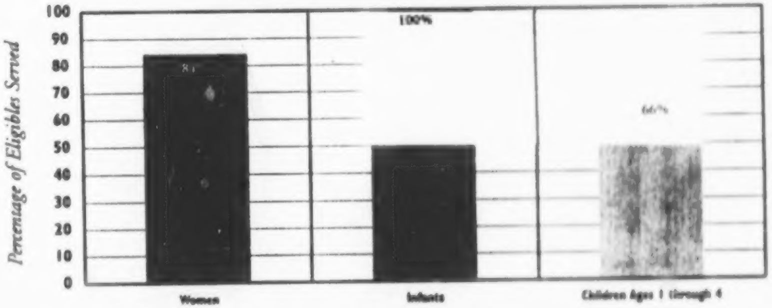
The Special Supplemental Nutrition Program for Women, Infants and Children is a preventive program providing nutritious food, nutrition education, and improved access to health care.[1] This federally-funded program serves pregnant, postpartum and breastfeeding women, infants, and children less than five years of age. Household income must be below 185% of the poverty level. In addition, any individual who participates in the Food Stamp program, RIte Care, Medicaid, cash assistance through the Family Independence Program, or is a member of a family in which a pregnant woman or infant receives Medicaid benefits, is deemed automatically income eligible.[2] Participants must have a specified health or nutritional risk, such as abnormal weight gain during pregnancy or iron deficiency anemia.

All WIC participants receive vouchers for food such as eggs, cereal, milk, cheese, infant formula, juice, carrots, and high protein foods (beans, peanut butter, tuna fish) that can be redeemed at retail stores.[3] The WIC Farmer's Market Nutrition Program improves the intake of fresh fruits and vegetables by providing coupons to WIC participants to help them to purchase fresh produce at local farmers' markets. In Rhode Island in 1999, nine farmers' markets provided fresh fruits and vegetables to more than 12,000 recipients.[4]

The WIC program is closely connected to the health care delivery system. Participation in WIC increases the likelihood that women will receive early, regular prenatal care and that their children will get regular pediatric care and immunizations.[5] WIC promotes breastfeeding as the optimal method of infant feeding. Breastfeeding mothers qualify for a special food package and program eligibility is extended for up to one year.[6]

WIC protects infants and children from iron-deficiency anemia and other nutrition-related health problems.[7] By protecting a child's cognitive development, WIC results in savings for special education that may have otherwise been incurred due to malnutrition in infancy and early childhood.[8] Mothers and children who are poor, minority, or poorly educated benefit most.[9]

Percentage of Eligible Women, Infants, and Children Served by WIC, Rhode Island, December 1999



◆ As of December 1999, it is estimated that 84% of eligible pregnant and postpartum women, 100% of eligible infants, and 66% of eligible children are served by WIC.

Source: Rhode Island Department of Health, Division of Family Health, WIC Program, December 1999

Access to WIC in Rhode Island

◆ In Rhode Island as of December 1999, there were 24,900 individuals enrolled in the WIC program. Of these, 22% were women, 23% were infants, and 55% were children ages 1 through 4.[10]

◆ WIC is not an entitlement program and is not funded at a level that is sufficient to serve all eligible women, infants, and children. Total WIC participation in Rhode Island increased from 3,173 women, infants and children in 1977 to 24,900 in 1999. As of December 1999, 76% of eligible women, infants and children were served across the state.[11]

◆ Four of the five cities with the highest child poverty rates — Providence, Pawtucket, Woonsocket, and Central Falls — have WIC participation rates that exceed the statewide average of 76%. In Newport, only 51% of women, infants, and children eligible for WIC are served.[12]

Women and Children Receiving WIC

Table 10. **Women, Infants and Children Receiving WIC, Rhode Island, December 1999**

CITY/TOWN	ESTIMATED NUMBER ELIGIBLE	NUMBER PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	211	35	17%
Bristol	403	195	48%
Burrillville	427	279	65%
Central Falls	1,642	1,472	90%
Charlestown	105	68	65%
Coventry	592	335	57%
Cranston	1,753	1,038	59%
Cumberland	554	288	52%
East Greenwich	241	47	20%
East Providence	1,205	889	74%
Exeter	13	47	100%*
Foster	10	50	100%*
Glocester	293	74	25%
Hopkinton	33	83	100%*
Jamestown	96	14	15%
Johnston	598	327	55%
Lincoln	360	181	50%
Little Compton	63	15	24%
Middletown	694	335	48%
Narragansett	71	116	100%*
Newport	1,332	684	51%
New Shoreham	39	2	5%
North Kingstown	370	255	69%
North Providence	262	406	100%*
North Smithfield	59	79	100%*
Pawtucket	3,198	2,983	93%
Portsmouth	249	118	47%
Providence	11,280	9,644	85%
Richmond	24	93	100%*
Scituate	75	69	92%
Smithfield	174	91	52%
South Kingstown	402	232	58%
Tiverton	260	162	62%
Warren	156	133	85%
Warwick	1,613	960	60%
Westerly	648	357	55%
West Greenwich	38	29	76%
West Warwick	777	704	91%
Woonsocket	2,566	2,011	78%
Core Cities	*20,018*	*16,794*	*84%*
Remainder of State	*12,868*	*8,106*	*63%*
Rhode Island	*32,886*	*24,900*	*76%*

**Estimates are based on 1990 Census, and do not reflect recent increases in eligible population.*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, WIC Program, December 1999.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of children under age 5 who live in families with an income less than 185% of poverty, according to the 1990 Census of Population. This is an estimate of the eligible population and does not take into account any increases or decreases in the number of women and children who became income eligible between 1990 and 1999.

References for Indicator

[1,3] Devaney, B.L., Ellwood, M.R., & Love, J.M. (1997). "Programs that Mitigate the Effects of Poverty on Children" in *The Future of Children: Children and Poverty,* Vol. 7, No. 2 (Summer/Fall 1997). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[11] Food Research and Action Center (1999). "Federal Food Programs: Special Supplemental Nutrition Program for Women, Infants, and Children."

[illegible] Rhode Island Department of Health, Division of Family Health, WIC Program, December 1999.

[13] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[8] *Statement on the Link Between Nutrition and Cognitive Development in Children* (1998). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

Women with Delayed Prenatal Care

DEFINITION

Women with delayed prenatal care is the percentage of women beginning prenatal care in the second or third trimester of pregnancy or receiving no prenatal care at all. Data are reported by place of mother's residence, not place of infant's birth.

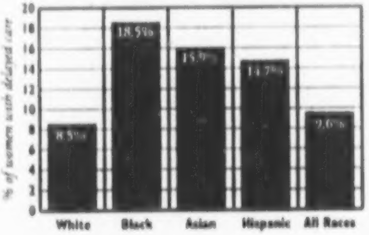
SIGNIFICANCE

Timely and comprehensive prenatal care increases the likelihood of delivering a healthy infant of normal birthweight, results in fewer complications at birth, and reduces health care costs.[1] Delaying the start of prenatal care to the second trimester increases health risks for both mother and baby.[2] Women receiving late or no prenatal care are at increased risk of having infants who are low birthweight, who are stillborn, or who die within the first year of life.[3]

Prenatal care offers the opportunity to screen for and treat disease conditions as well as intervene with non-medical conditions including smoking, substance use, physical abuse, nutritional deficiencies, and needs for food, clothing and shelter.[4] Women who receive adequate prenatal care are more likely to get preventive health care for their children, such as scheduling well-baby visits, immunizations, and regular health checkups.[5,6]

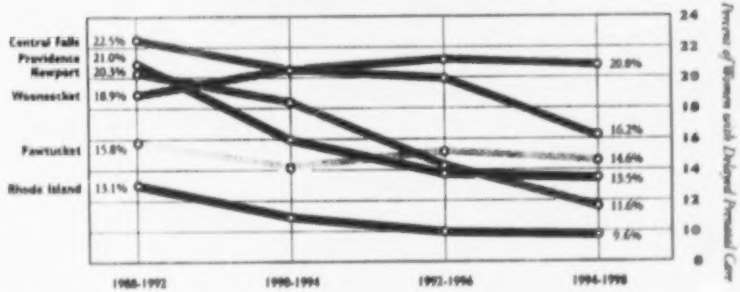
Early prenatal care is especially important for women at increased medical and social risk.[7] Several studies have indicated that low-income women who receive enhanced prenatal care services experience improved birth outcomes. Enhanced prenatal care services may include outreach, case management, risk assessment, smoking cessation, nutritional and psychosocial counseling, health education, guidance on infant and child development, referrals to WIC and other social services, and home visits.[8]

Delayed Prenatal Care, by Race/Ethnicity, Rhode Island, 1994-1998



Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1994-1998. Data for 1996-1998 are provisional.

Delayed Prenatal Care, Core Cities and Rhode Island, 1988-1998



◆ Women who live in the core cities continue to be less likely to begin prenatal care in the first trimester. In Central Falls more than 20% of women received late or no prenatal care, twice the state rate for delayed care. The communities of Providence and Newport have significantly improved access to prenatal care over the past decade.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, five-year averages of data from 1988-1992, 1990-1994, 1992-1996, and 1994-1998. Data for 1996-1998 are provisional.

Risk Factors for Delayed Prenatal Care

◆ Over the past decade, access to prenatal care has improved for Rhode Island women of all racial and ethnic groups. Black, Asian, and/or Hispanic women continue to be almost twice as likely as white women to begin prenatal care after the first trimester.[10]

◆ In every racial and ethnic group, women with more education are more likely to receive early prenatal care and to have more visits.

◆ Adolescents, regardless of race, are less likely to receive early prenatal care than older mothers. In Rhode Island from 1994 to 1998, 22% of pregnant women ages 12 to 19 did not receive prenatal care until after the first trimester compared to 8% of women over age 20.

Women with Delayed Prenatal Care

Table 11

Delayed Prenatal Care, Rhode Island, 1994-1998

CITY/TOWN	# BIRTHS	# DELAYED CARE	% DELAYED CARE
Barrington	785	21	2.7%
Bristol	1,180	94	8.0%
Burrillville	824	63	7.6%
Central Falls	1,641	342	20.8%
Charlestown	408	28	NA
Coventry	1,946	117	6.0%
Cranston	4,203	299	7.1%
Cumberland	1,669	97	5.8%
East Greenwich	598	28	4.7%
East Providence	2,688	224	8.3%
Exeter	362	24	NA
Foster	208	12	NA
Glocester	508	29	5.7%
Hopkinton	484	44	NA
Jamestown	215	7	NA
Johnston	1,582	99	6.3%
Lincoln	962	51	5.3%
Little Compton	134	8	NA
Middletown	1,147	90	7.8%
Narragansett	728	21	2.9%
Newport	1,713	198	11.6%
New Shoreham	69	7	NA
North Kingstown	1,486	64	4.3%
North Providence	1,679	113	6.7%
North Smithfield	472	26	NA
Pawtucket	5,086	742	14.6%
Portsmouth	940	45	4.8%
Providence	13,439	1,816	13.5%
Richmond	480	30	NA
Scituate	508	21	4.1%
Smithfield	865	33	3.8%
South Kingstown	1,330	55	4.1%
Tiverton	516	41	7.9%
Warren	604	52	8.6%
Warwick	4,671	265	5.7%
Westerly	1,431	168	11.7%
West Greenwich	316	14	NA
West Warwick	2,058	193	9.4%
Woonsocket	2,872	465	16.2%
Core Cities	*24,751*	*3,563*	*14.4%*
Remainder of State	*38,056*	*2,483*	*6.5%*
Rhode Island	*62,807*	*6,016*	*9.6%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1994-1998. Data for 1996-1998 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

NA: Percentages were not calculated for cities and towns with less than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1994-1998. Data for 1996-1998 are provisional.

References for Indicator

[1,7] Child Trends, Inc. and the U.S. Bureau of the Census (1997). *Trends in the Well-Being of America's Children and Youth: 1997.* Washington, DC: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation.

[2,3] *Prenatal Care in the United States: A State and County Inventory - Volume I* (1989). New York: The Alan Guttmacher Institute.

[3,4] Klerman, L.V. (1991). *Alive and Well?: A Research and Policy Review of Health Programs for Poor Children.* New York: Columbia University, National Center for Children in Poverty.

[4] Alexander, G.R. & Korenbrot, C.C. (1995). "The Role of Prenatal Care in Preventing Low Birth Weight" in *The Future of Children: Low Birth Weight,* Vol. 5, No. 1 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[5] Children Defense Fund (1998). "New Data Show Prenatal, Postdelivery Progress" in *CDF Reports* (October 1998). Washington, DC: Children's Defense Fund.

[6] *Maternal and Child Health Principles in Practice: An Analysis of Select Provisions in Medicaid Managed Care Contracts* (1998). Washington, DC: Association of Maternal and Child Health Programs and George Washington University Medical Center, Center for Health Policy Research.

[7,8] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1994-1998. Data for 1996-1998 are provisional.

[9] National Center for Health Statistics (1998). *Health, United States, 1998.* Hyattsville, MD: U.S. Public Health Service.

Low Birthweight Infants

DEFINITION

Low birthweight infants is the percentage of infants born weighing under 2,500 grams (5.5 pounds). The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

A baby's birthweight is a key indicator of newborn health and is directly related to infant survival, health and development. Babies born weighing less than 5.5 pounds are at greater risk for physical and developmental problems.[1] Babies are born small for a number of reasons: some are born too soon (premature), some are born full-term but small for their gestational age, and some are born both premature and small.[2]

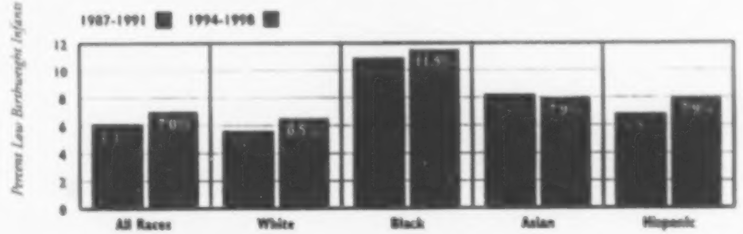
The incidence of low birthweight is strongly associated with poverty.[3] Prevention of low birthweight focuses on early and comprehensive prenatal care, adequate nutrition and weight gain, and smoking cessation. Smoking during pregnancy has been linked to 20% to 30% of low birthweight births and to long-term effects such as physical, mental, and cognitive impairments.[4]

Low birthweight babies are at higher risk of death or long-term illness and disability than are infants of normal birthweight.[5] Low birthweight babies are 20 times more likely than babies of normal weight to die within the first year of life.[6] Low birthweight infants who survive are at greater risk for physical and developmental problems. Children who are now 6 to 15 years old, who were born low birthweight, are 50% more likely than children born of normal weight to be enrolled in a special education program.[7]

Black women are much more likely to have a low birthweight infant than women of any other racial or ethnic group.[8] Underlying the high rate of low birthweight among African-Americans in the U.S. is the higher rate of preterm delivery (babies born before 37 weeks gestation).[9] The causes of preterm delivery are not well understood; the higher rates are not completely explained by differences in socio-economic status, health status, or use of tobacco or other drugs.[10,11]

Between 1994 and 1998, there were 808 very low birthweight infants (weighing less than 1,500 grams or 3.3 pounds) born in Rhode Island.[12] Very low birthweight babies are at especially high risk for chronic lung and respiratory problems, visual and hearing impairments, mental retardation, and developmental and learning disabilities.[13]

Low Birthweight Infants by Race/Ethnicity, Rhode Island, 1987-1991 and 1994-1998



◆ Between the late 1980s and the late 1990s in Rhode Island, the rate of low birthweight infants has increased slightly for all race and ethnic groups except Asians.

◆ Low birthweight rates for black infants in Rhode Island are almost twice those for white infants, and are higher than those for other racial groups.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database. 1987-1991, 1994-1998. Data for 1996-1998 are provisional. Hispanic data are not available for 1987 and 1988.

Increase in Low Birthweight Rates in the U.S.

◆ Nationally, the percent of low birthweight infants has steadily increased since 1984. In 1998 the rate was the highest since 1973.[14] Two primary reasons for the increase in low birthweight infants are the increasing number of multiple births and new developments in the neonatal field that make it possible for low birthweight, preterm infants to survive.[15,16]

◆ Twins and other multiple births are more likely to be low birthweight.[17] Between 1994 and 1998, half of the twins born in Rhode Island were low birthweight, and 90% of the triplets born were low birthweight.[18]

◆ Changes in medical technology, improvements in neonatal intensive care, and new drug therapies for very small infants have increased the chances that even very low birthweight infants will survive.[19] While low birthweight rates have increased over the last decade, infant death rates have decreased.[20]

Table 12. Low Birthweight Infants, Rhode Island, 1994-1998

CITY/TOWN	# BIRTHS	# LOW BIRTHWEIGHT	% LOW BIRTHWEIGHT
Barrington	785	54	6.9%
Bristol	1,180	77	6.5%
Burrillville	824	44	5.3%
Central Falls	1,641	141	8.6%
Charlestown	408	22	NA
Coventry	1,946	111	5.7%
Cranston	4,203	298	7.1%
Cumberland	1,669	98	5.9%
East Greenwich	598	41	6.9%
East Providence	2,688	183	6.8%
Exeter	362	6	NA
Foster	208	9	NA
Glocester	508	32	6.3%
Hopkinton	484	34	NA
Jamestown	215	13	NA
Johnston	1,582	102	6.4%
Lincoln	962	52	5.4%
Little Compton	134	7	NA
Middletown	1,147	52	4.5%
Narragansett	728	42	5.8%
Newport	1,713	113	6.6%
New Shoreham	69	4	NA
North Kingstown	1,486	76	5.1%
North Providence	1,679	145	8.6%
North Smithfield	472	37	NA
Pawtucket	5,086	398	7.8%
Portsmouth	940	41	4.4%
Providence	13,439	1160	8.6%
Richmond	480	19	NA
Scituate	508	39	7.7%
Smithfield	865	40	4.6%
South Kingstown	1,330	72	5.4%
Tiverton	516	29	5.6%
Warren	604	42	7.0%
Warwick	4,671	286	6.1%
Westerly	1,431	85	5.9%
West Greenwich	316	15	NA
West Warwick	2,058	162	7.9%
Woonsocket	2,872	213	7.4%
Core Cities	*24,751*	*2,025*	*8.2%*
Remainder of State	*38,056*	*2,369*	*6.2%*
Rhode Island	*62,807*	*4,394*	*7.0%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1994-1998. Data for 1996-1998 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

NA: Percentages were not calculated for cities and towns with less than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1994-1998.

References for Indicator

[1,6] Children's Defense Fund (1996)."Infant Health Improving" in *CDF Reports*, Vol. 17, No. 12 (November 1996). Washington, DC: Children's Defense Fund.

[2,5,17] *America's Children: Key National Indicators of Well-Being (1999).* Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[3,9,16] Paneth, N.S. (1995). "The Problem of Low Birthweight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucile Packard Foundation.

[4] Chomitz, V.R., Cheung, L.W.Y., Lieberman, E., "The Role of Lifestyle in Preventing Low Birth Weight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children.

[7] Lewit, E., Schuurmann Baker, L., Corman, H., Shiono, P.H. (1995). "The Direct Cost of Low Birth Weight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucile Packard Foundation.

[8,11,14,15] *National Vital Statistics Reports*, Vol. 47, No. 25 (October 5, 1999). Washington, DC: Centers for Disease Control, National Center for Health Statistics, National Vital Statistics System.

[12,18,20] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1994-1998. Data for 1997 and 1998 are provisional.

[13] Vohr, B.R. & Msall, M.E. (1997). "Neuropsychological and Functional Outcomes of Very Low Birthweight Infants" in *Seminars in Perinatology*, Vol. 21, No. 3 (June 1997); and Paneth, N.S. (1995). "The Problem of Low Birthweight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucile Packard Foundation.

[19] Children Defense Fund (1998). "New Data Show Prenatal, Postdelivery Progress" in *CDF Reports* (October 1998). Washington, DC: Children's Defense Fund.

[10] Lewit, E., Schuurmann Baker, L., Corman, H., & Shiono, P.H. (1995). "The Direct Cost of Low Birth Weight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: Center for the Future of Children; and Shiono, P.H., & Behrman, R.E. (1995). "Low Birth Weight: Analysis and Recommendations" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children.

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Infant Mortality

DEFINITION

Infant mortality is the number of deaths occurring to infants under one year of age per 1,000 live births. The data are reported by place of mother's residence, not place of infant's birth.

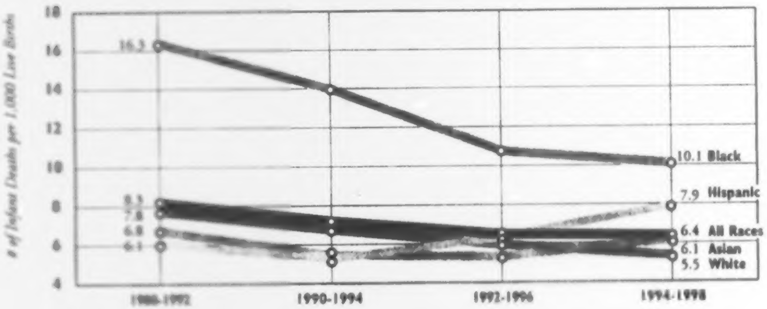
SIGNIFICANCE

The infant mortality rate is an important measure of the well-being of infants, children, and pregnant women. Infant mortality is associated with a variety of factors, including women's health status, quality of and access to medical care, socioeconomic conditions, and public health practices. In the United States, about two-thirds of infant deaths are closely linked to low birthweight, preterm delivery, and events surrounding the prenatal period and delivery; about one-third are associated with conditions or events that arise after the delivery, which often reflect social or environmental factors.[1,2]

Communities with multiple problems such as poverty, poor housing conditions, and unemployment tend to have higher infant mortality rates than more advantaged communities.[3] Risk factors contributing to infant deaths include a lack of preventive health and prenatal care, inadequate nutrition, and poor living conditions. Some of the health factors associated with infant deaths include congenital birth defects, complications resulting from early delivery and low birthweight, and respiratory problems.[4]

Infant mortality has two components: neonatal mortality, which is the number of deaths of infants younger than 28 days, and postneonatal mortality, the number of deaths of infants between 28 days and one year old. In 1998 in Rhode Island, 87 infants died before their first birthday; of these, 64 were younger than 28 days old. Fifty-three of the 87 infants who died in 1998 were born very low birthweight (less than 1500 grams or 3.3 pounds); of these, 30 were live births less than 500 grams (1.1 pounds).[5]

Infant Mortality by Race/Ethnicity, Rhode Island, 1988-1998



◆ Over the past decade, Rhode Island's infant mortality rate declined for white, black, and Asian infants, but increased for Hispanic infants.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, five-year averages of data from 1988-1992, 1990-1994, 1992-1996, and 1994-1998. Data for 1996-1998 are provisional. Hispanic data for 1988 are not available.

Infant Mortality Rate Steadily Improves but the U.S. Still Lags Behind Other Countries

◆ Improved access to prenatal care in the first trimester, wider used of medical technology that detects problems early on, and improvements in neonatal care have contributed to a decrease in infant mortality rates across the United States.[6]

◆ Between 1980 and 1998 the national infant mortality rate decreased from 12.6 to 7.2 infant deaths per 1000 births.[7,8] The overall U.S. infant mortality rate ranks 30th worldwide.[9]

◆ In 1998, the U.S. infant mortality rate for black infants was 14.2 deaths per 1,000 births. The U.S. infant mortality rate for black infants ranks 47th when compared to other countries' overall rates.[10]

88

89

Infant Mortality

Table 13.

Number of Infant Deaths, Rhode Island, 1994-1998

CITY/TOWN	# BIRTHS	# INFANT DEATHS	RATE/1000 BIRTHS
Barrington	785	1	1.3
Bristol	1,180	5	4.2
Burrillville	824	8	9.7
Central Falls	1,641	11	6.7
Charlestown	408	1	NA
Coventry	1,946	7	3.6
Cranston	4,203	20	4.8
Cumberland	1,669	8	4.8
East Greenwich	598	3	5.0
East Providence	2,688	11	4.1
Exeter	362	1	NA
Foster	208	0	NA
Glocester	508	5	9.8
Hopkinton	484	3	NA
Jamestown	215	0	NA
Johnston	1,582	6	3.8
Lincoln	962	4	4.2
Little Compton	134	0	NA
Middletown	1,147	7	6.1
Narragansett	728	3	4.1
Newport	1,713	7	4.1
New Shoreham	69	1	NA
North Kingstown	1,486	7	4.7
North Providence	1,679	13	7.7
North Smithfield	472	3	NA
Pawtucket	5,086	36	7.1
Portsmouth	940	6	6.4
Providence	13,439	128	9.5
Richmond	480	2	NA
Scituate	508	2	3.9
Smithfield	865	4	4.6
South Kingstown	1,330	10	7.5
Tiverton	516	3	5.8
Warren	604	1	1.7
Warwick	4,671	26	5.6
Westerly	1,431	7	4.9
West Greenwich	316	0	NA
West Warwick	2,058	17	8.3
Woonsocket	2,872	22	7.7
Core Cities	*24,751*	*204*	*8.2*
Remainder of State	*38,056*	*195*	*5.1*
Rhode Island	*62,807*	*399*	*6.4*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1994-1998. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

NA: Rates were not calculated for cities and towns with less than 500 births, as rates for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1994-1998.

References for Indicator

[1] *America's Children: Key National Indicators of Well-Being (1999).* Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2] Paneth, N.S. (1995). "The Problem of Low Birth Weight" in *The Future of Children: Low Birth Weight,* Vol.5, No.1 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[3,4,5] *The State of the World's Children: 2000* (2000). New York: United Nations Children's Fund (UNICEF).

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[7] Provisional data on 12,201 births. Rhode Island Department of Health, Office of Vital Statistics, January 2000.

[8,9] Children Defense Fund (1998). "New Data Show Prenatal, Postdelivery Progress" in *CDF Reports,* Vol. 17, No. 12 (October 1998). Washington, DC: Children's Defense Fund.

Children with Lead Poisoning

DEFINITION

Children with lead poisoning is the percentage of three-year-old children screened for lead poisoning who had elevated blood lead levels (10 ug/dL) at any time prior to November 30, 1999. These data are for children eligible to enter kindergarten in the fall of 2001 (i.e. born between September 1, 1995 and August 31, 1996).

SIGNIFICANCE

Childhood lead poisoning is one of the most common pediatric health problems and is entirely preventable. Infants, toddlers, and pre-school age children are most susceptible to the toxic effects of lead. Lead's effects on the developing central nervous system may be irreversible.[1] Learning disabilities, hyperactivity, antisocial behavior, attention deficit disorder, hearing and speech impediments, and loss of intelligence can be attributed to lead levels equal to or greater than 10 ug/dL. Higher levels of lead exposure can result in serious health problems and can lead to coma, convulsions, and death.[2,3]

A strong link has been established between low level lead exposure in early childhood and later decreased academic performance.[4] Children with lead exposure are more likely to require special education services.[5] Children with chronic exposure are more likely to have lowered IQ, behavioral problems, and as a result, academic failure and increased risk for juvenile delinquency.[6]

While all children are at risk for lead poisoning, low-income children and minority children are particularly likely to be affected.[7] The lack of affordable housing in many communities means that many low-income families live in older dwellings with deteriorating lead paint, placing children at risk for lead poisoning.[8] Inadequate nutrition and anemia, more common in low-income children, further increase a child's susceptibility to lead poisoning.[9]

Because children may not display obvious symptoms of lead exposure, the best way to detect the condition is through a screening blood test.[10] The Childhood Lead Poisoning Prevention Act of 1991 requires regular lead screening for all Rhode Island children under age 6. In a study of all children born in Rhode Island hospitals in the first four months of 1996, two-thirds of the children were screened for lead by 18 months of age.[11]

Progress has been made in reducing the number of children under age six with lead exposure. Thirty-five percent (3,910) of children eligible to enter kindergarten in the fall of 1996 had been screened with a blood lead level over 10 ug/dL as compared to 13% (1,873) of children eligible to enter kindergarten in the fall of 2001.[12]

Lead Exposure in Children under Age 6, Rhode Island and Core Cities, Screened between July 1, 1998 and June 30, 1999

	NUMBER SCREENED	NUMBER WITH ELEVATED LEAD LEVELS (≥10UG/DL)	PERCENT WITH ELEVATED LEAD LEVELS (≥10 UG/DL)
Providence	7,716	1,463	19%
Central Falls	1,059	189	18%
Woonsocket	2,043	273	13%
Pawtucket	2,833	345	12%
Newport	881	92	10%
Core Cities	*14,532*	*2,362*	*16%*
Rhode Island	*33,696*	*3,422*	*10%*

Source: RI Department of Health, Office of Occupational and Radiological Health and Division of Family Health. Data are for all children screened between July 1, 1998 and June 30, 1999 (n=33,696). Communities may vary in the percentage of children under age 6 who are screened.

◆ In 1999, more than two-thirds (69%) of children screened with high lead levels lived in the core cities. Of the 2,362 children with high lead levels statewide, 560 had very high lead levels over 20 ug/dL. Seven children were hospitalized with lead poisoning; of these, 5 lived in Providence and 2 lived in Woonsocket.

◆ One in five children screened in Providence and Central Falls in 1999 had high lead levels, compared to just over one in ten statewide.

Lead Poisoning Prevention and Treatment

◆ Lead poisoning is a multi-dimensional problem involving housing and health. Lead poisoning can be prevented through public-private sector partnerships that reduce lead hazards in housing and educate the public on the risks of lead poisoning to young children.[13]

◆ The Centers for Disease Control recommends a multidisciplinary comprehensive approach to the treatment of lead poisoned children, including: repeat blood tests to monitor lead levels, medical management, house inspections, removal of lead hazards, child development services, social services, and parent education.[14,15]

Children with Lead Poisoning

Table 14.

Lead Poisoning in Children Entering Kindergarten in the Fall of 2001

CITY/TOWN	NUMBER TESTED FOR LEAD POISONING	# SCREENED POSITIVE >=10 UG/DL	% CHILDREN >=10 UG/DL
Barrington	237	13	5.5%
Bristol	308	24	7.8%
Burrillville	177	29	16.4%
Central Falls	416	109	26.2%
Charlestown	93	7	7.5%
Coventry	387	20	5.2%
Cranston	891	82	9.2%
Cumberland	381	16	4.2%
East Greenwich	158	3	1.9%
East Providence	583	51	8.7%
Exeter	73	2	2.7%
Foster	55	1	1.8%
Glocester	80	3	3.8%
Hopkinton	82	5	6.1%
Jamestown	51	14	27.5%
Johnston	333	15	4.5%
Lincoln	238	20	8.4%
Little Compton	48	3	6.3%
Middletown	204	12	5.9%
Narragansett	173	10	5.8%
Newport	356	49	13.8%
New Shoreham	11	0	0.0%
North Kingstown	378	20	5.3%
North Providence	311	18	5.8%
North Smithfield	106	5	4.7%
Pawtucket	1,125	165	14.7%
Portsmouth	206	9	4.4%
Providence	3,082	770	25.0%
Richmond	102	6	5.9%
Scituate	133	6	4.5%
Smithfield	211	5	2.4%
South Kingstown	379	35	9.2%
Tiverton	174	14	8.0%
Warren	134	17	12.7%
Warwick	973	60	6.2%
Westerly	140	11	7.9%
West Greenwich	68	1	1.5%
West Warwick	426	34	8.0%
Woonsocket	794	119	15.0%
Unknown Residence	*540*	*90*	*NA*
Core Cities	*5,773*	*1,212*	*21.0%*
Remainder of State	*8,304*	*571*	*6.9%*
Rhode Island	*14,617*	*1,873*	*12.8%*

Source of Data for Table/Methodology

Rhode Island Department Health, Office of Occupational and Radiological Health and Division of Family Health, November 1999.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

Data for children entering kindergarten in the fall of 2001 reflects the number of RI children eligible to enter school in the fall of 2001 (i.e. born between 9/1/95 and 8/31/99) who screened positive for lead poisoning at anytime prior to November 30, 1999. Rhode Island law requires universal lead screening for children under six. Lead screening results for close to 100% of Rhode Island children in this age cohort are included in this indicator.

The denominator is the number of children entering school in the fall of 2001 who were screened for lead poisoning.

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Births to Teens

DEFINITION

Births to teens is the number of births to teen girls ages 15 to 17 per 1,000 teen girls. Data are reported by the mother's place of residence, not the place of the infant's birth.

SIGNIFICANCE

Teen pregnancy and parenting threatens the development of teen parents as well as their children. Teen mothers are less likely to obtain adequate prenatal care and are less likely to have financial resources and social supports needed for healthy child development.[1] Children born to teen parents are more likely to suffer poor health, experience learning and behavior problems, live in poverty, go to prison, and become teen parents themselves.[2]

While teen pregnancy occurs in families of all income levels, teens who give birth are more likely to come from economically disadvantaged families and communities.[3] In the U.S., 83% of teens who give birth and 61% of teens who have abortions are from poor or low-income families.[4] Teen moms are more likely to have mothers who have completed fewer years of schooling and to have mothers or older sisters who also gave birth as adolescents.[5]

Poor academic achievement is a key predictor of teen pregnancy.[6,7] Nationally, three out of five teen mothers drop out of school.[8] Being a teen parent seriously limits subsequent education and employment prospects.[9] Teen parents are more likely to delay or not finish school, putting them at greater risk of facing unemployment, low-wage jobs, and poverty.[10]

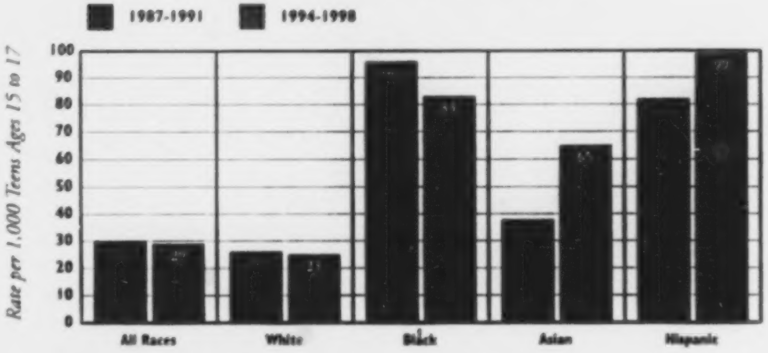
In Rhode Island between 1994 and 1998, there were 152 babies born to girls ages 12 to 14 and 2,494 babies born to girls ages 15 to 17. Between 1994 and 1998, 59% of teen pregnancies resulted in live births, 38% resulted in abortion, and 3% resulted in miscarriage.[11] In Rhode Island in 1997, almost one in five (20%) births to teen girls ages 15 to 19 were repeat births. Rhode Island ranks in the top half of states for repeat births to teens — 22nd in the country.[12]

Teen Births in the Core Cities

◆ **Between 1994 and 1998, two out of three births to teens ages 15 to 17 were to girls in the cities of Providence, Pawtucket, Woonsocket, Newport and Central Falls.[13]**

◆ **In 1997 in Providence, 20% of all births were to teens under age 20 compared to 11% in Rhode Island, and 15% in 50 major U.S. cities.[14]**

Births to Teens Ages 15-17, by Race/Ethnicity,
Rhode Island, 1987-1991 and 1994-1998



◆ **Between 1987-1991 and 1994-1998 in Rhode Island, the birth rate for white teens remained level, the birth rate for black teens decreased by 14%, the birth rate for Asian teens almost doubled, and the birth rate for Hispanic teens increased by 21%.**

◆ **Between 1987-1991 and 1994-1998, the birth rate for Hispanic teens in Rhode Island increased from 82 births/1,000 teens ages 15 to 17 to 99 births/1,000 teens. In Rhode Island in 1994-1998, the birth rate for Hispanic teens was more than three times the birth rate for all teens.**

◆ **Since 1994, Hispanic teens have had the highest teen birth rate among major racial/ethnic groups in the U.S. In 1997, the U.S. birth rate for Hispanic teens ages 15 to 19 was nearly double the overall rate for teens ages 15 to 19.[15]**

Source: Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, five-year averages of data from 1987-1991 and 1994-1998. Data for 1996-1998 are provisional. Hispanic data are not available for 1987 and 1988.

Table 15

Births to Teens, Ages 15-17, Rhode Island, 1994-1998

CITY/TOWN	# OF TEEN GIRLS AGES 15-17	# OF BIRTHS TO TEENS AGES 15-17	RATE PER 1,000 TEENS
Barrington	1,410	5	3.5
Bristol	1,845	23	12.5
Burrillville	1,605	20	12.5
Central Falls	1,545	92	59.5
Charlestown	485	12	NA
Coventry	3,065	47	15.3
Cranston	5,685	92	16.2
Cumberland	2,740	33	12.0
East Greenwich	1,360	7	5.1
East Providence	4,320	65	15.0
Exeter	585	5	8.5
Foster	450	4	NA
Glocester	1,030	6	5.8
Hopkinton	670	12	17.9
Jamestown	400	3	7.5
Johnston	2,225	23	10.3
Lincoln	1,610	19	11.8
Little Compton	255	2	NA
Middletown	1,470	21	14.3
Narragansett	1,020	14	13.7
Newport	1,950	86	44.1
New Shoreham	25	0	NA
North Kingstown	2,385	25	10.5
North Providence	2,575	40	15.5
North Smithfield	1,165	7	6.0
Pawtucket	6,430	262	40.7
Portsmouth	1,710	14	8.2
Providence	13,395	1,036	77.3
Richmond	510	13	25.5
Scituate	1,080	6	5.6
Smithfield	1,430	8	5.6
South Kingstown	1,830	32	17.5
Tiverton	1,405	16	11.4
Warren	910	21	23.1
Warwick	7,275	111	15.3
Westerly	1,785	42	23.5
West Greenwich	365	2	NA
West Warwick	2,400	64	26.7
Woonsocket	3,995	204	51.1
Core Cities	*27,315*	*1,680*	*61.5*
Remainder of State	*59,080*	*814*	*13.8*
Rhode Island	*86,395*	*2,494*	*28.9*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, 1994-1998. Data for 1996-1998 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

NA: Rates were not calculated for cities and towns with less than 100 teen girls ages 15 to 17, as rates for small denominators are statistically unreliable.

The denominator is the number of girls ages 15 through 17 according to the 1990 Census of Population, multiplied by five to compute a rate over five years, 1994-1998.

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Alcohol, Drug, and Cigarette Use by Teens

DEFINITION

Alcohol, drug and cigarette use by teens is the percentage of seventh-grade, ninth-grade, and twelfth-grade students who have used alcohol or marijuana in the past month or are current smokers, based on the *1998 Rhode Island Adolescent Substance Abuse Survey.*

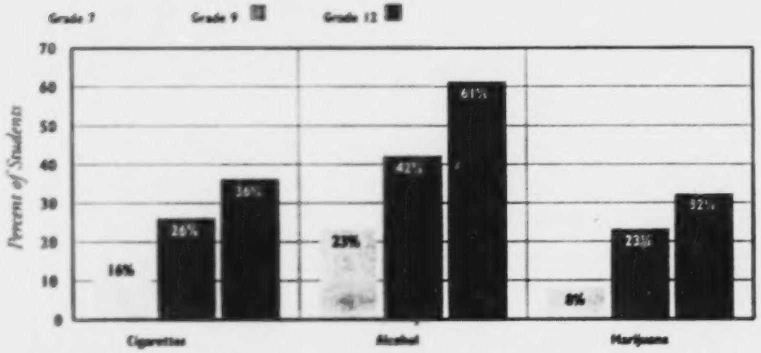
SIGNIFICANCE

The use of substances threatens the health and safety of children, families, and communities. Children and teens are negatively affected by the emotional and financial hardships caused by parents with substance abuse problems.[1] Eighteen percent of Rhode Island seventh to twelfth graders surveyed in 1998 reported that the drinking of one or both of their parents caused problems.[2] Abuse of alcohol and drugs is implicated in unemployment, worker absenteeism, accidents, vandalism, fires, damaged and destroyed playgrounds and housing, violent crimes, poverty, and homelessness.[3]

Substance use has been shown to cause dependency, mood changes, impaired judgment, memory loss, and prolonged aimlessness.[4] Young people who abuse alcohol and drugs are more likely to drop out of school, become teen parents, engage in high-risk sexual behavior, experience injuries, and become involved with the criminal justice system.[5] The number of Rhode Island juveniles referred to Family Court for drug and alcohol offenses in 1999 was 341. This is a decrease of 20% from 1998.[6]

The younger the age at which people start smoking cigarettes, the more likely they are to become strongly addicted to nicotine. Of adult daily smokers, 89% tried their first cigarette by age 18.[7] Smoking has serious long-term consequences, including the risk of smoking-related diseases, increased health care costs associated with treating these illnesses, and the risk of premature death. It is estimated that more than five million of today's underage smokers will die of tobacco-related illnesses.[8]

Use of Cigarettes, Alcohol, and Marijuana, by Student Grade Level, Rhode Island, 1998



Student has smoked at least one cigarette in the past month or has used alcohol or marijuana in the past month. Based on a survey of 5,644 students in seventh grade; 4,350 students in ninth grade; and 2,401 students in twelfth grade.

Source: *1998 Rhode Island Adolescent Substance Abuse Survey: Report of Statewide Results.* Rhode Island Department of Health, Office of Health Statistics.

Drug, Alcohol, and Tobacco Use by Elementary School Students

◆ A recent national study indicates that children are experimenting with substances such as marijuana, inhalants, and alcohol as early as fourth grade.[15]

◆ The most significant increase in use of these substances occurred in the sixth grade, at which time 4% of U.S. youth in the survey had tried marijuana, 7% had tried inhalants, 15% had tried beer, 9% had tried hard liquor, and 15% had tried cigarettes.[16]

◆ In a 1997 survey of Rhode Island high school students, 34% had tried alcohol before age 13, 11% percent had tried marijuana before age 13, and 24% had smoked a whole cigarette before age 13.[17]

Alcohol, Drug, and Cigarette Use by Teens

Alcohol Use and Youth

◆ Alcohol is the leading substance of abuse at all grade levels in Rhode Island, according to the *1998 Rhode Island Adolescent Substance Abuse Survey.* The prevalence of alcohol use among Rhode Island students is higher than national rates.[9]

◆ Almost one in four (23%) Rhode Island seventh-grade students, almost half (42%) of ninth-graders, and almost two-thirds (61%) of twelfth-graders reported using alcohol in the past month.[10]

◆ In Rhode Island in 1998, 16% of eighth graders reported being drunk in the past month, and 41% of twelfth graders reported being drunk in the past month.[11]

◆ Drinking and driving is a significant problem for teenagers. Studies show that 29% of traffic fatalities involving 15-17 year-olds were alcohol related.[12] In 1997 in Rhode Island, 46% of twelfth graders reported riding in a car in the past month with someone who had been drinking alcohol.[13]

◆ A 1999 study of teen drug and alcohol use by the U.S. Department of Health and Human Services found that alcohol use has remained stable in the past few years among 8th, 10th and 12th graders.[14]

Cigarette Use Among Youth

◆ Among U.S. teens ages 12 to 17, the incidence of first use of cigarettes has been rising continuously during the 1990's and has been steadily higher than for persons ages 18 to 25 since the 1970's.[18]

◆ Smoking among twelfth graders in the U.S. steadily increased from 17% in 1992 to 25% in 1997. Between 1997 and 1998, smoking among twelfth-graders decreased from 25% to 22%.[19]

◆ According to the *1998 Rhode Island Adolescent Substance Abuse Survey,* 26% of ninth graders and 36% of twelfth graders reported that they had smoked at least one cigarette in the past month. Almost half of all students reported that one or both parents smoked.[20]

◆ A comprehensive approach to prevention can keep young people from initiating tobacco use and can help adolescents quit smoking.[21]

◆ A comprehensive approach to preventing tobacco use includes efforts to: reduce access and appeal of tobacco products; conduct media and school-based tobacco prevention programs; increase the availability of smoke-free environments; decrease tobacco use by parents, teachers and role models; and implement effective youth cessation programs.[22]

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Children with Asthma

DEFINITION

Children with asthma is the annual number of hospitalizations for asthma among children under age 18. Data are reported by place of child's residence at the time of hospitalization.

SIGNIFICANCE

Asthma is a chronic breathing disorder and one of the most common chronic health problems among children.[1] Asthma attacks may occur when children get respiratory infections, including those caused by common cold viruses. Asthma can be triggered by: exposure to cigarette smoke, dust in the home, stress, strenuous exercise, allergies, roach infestation, indoor and outdoor air pollutants, and weather conditions.[2,3] Childhood asthma in the U.S. increased from 43 per 1,000 children in 1984 to 75 per 1,000 children in 1995.[4]

National studies indicate that most of the potentially avoidable hospitalizations of children younger than age 15 are for pneumonia or asthma.[5] In Rhode Island in 1998, more than twenty percent of all child hospitalizations were for respiratory-related reasons; of these, almost one third were for asthma.[6] Asthma is a leading cause of school absences and time lost from work.[7,8] Asthma is more common among low-income and minority children living in poor neighborhoods or in crowded housing.[9,10]

Managing asthma requires a long-term, multifaceted approach, including patient education, behavior changes, avoidance of asthma triggers, medicines to minimize and prevent symptoms, prompt treatment, and frequent medical follow-up.[11,12] Insured children are twice as likely as uninsured children to receive ongoing asthma care from a physician. Low-income and uninsured children are more likely to receive treatment in the emergency room or be hospitalized for conditions that could have been managed with appropriate outpatient care.[13]

Childhood Asthma Hospitalization Rates, Core Cities and Rhode Island, 1998

City/Town	Number of Children Hospitalized	Rate per 1,000 Children
Providence	146	3.9
Woonsocket	39	3.9
Newport	13	2.4
Pawtucket	35	2.2
Central Falls	6	1.3
Core Cities	239	3.3
Rhode Island	424	1.9

Source: Rhode Island Department of Health, Hospital Discharge Database, 1998. Data are for Fiscal Year 1998, from July 1, 1997 to June 30, 1998.

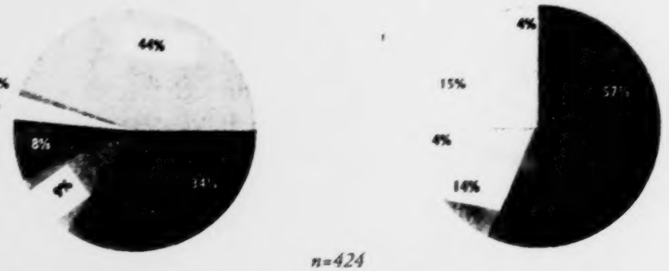
Asthma Hospitalizations, Rhode Island Children Under Age 18, July 1, 1997 to June 30, 1998

By Core Cities

34%	■	Providence
9%	▨	Woonsocket
8%	■	Pawtucket
3%		Newport
1%	▨	Central Falls
44%		Remainder of State

By Race/Ethnicity

57%	■	White
14%	▨	Black
4%	■	Asian
15%		Hispanic
6%	■	Other
4%		Unknown



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Source: Rhode Island Department of Health, Hospital Discharge Database, 1998. Data are for Fiscal Year 1998, from July 1, 1997 to June 30, 1998.

◆ In Rhode Island in 1998, more than half (56%) of all hospitalizations for childhood asthma were children residing in the core cities of Providence, Pawtucket, Woonsocket, Newport, and Central Falls, which also have the highest child poverty rates in the state.[14]

◆ While 16% of Rhode Island children are from a minority racial or ethnic group, 33% of hospitalizations for childhood asthma were Black, Asian, and Hispanic children.[15]

◆ Most cases of childhood asthma can be managed by the child's primary care physician. Accessible and timely medical care can prevent severe episodes of asthma. Hospitalization for asthma may indicate that the child has not had adequate outpatient management for the disease.[16,17]

Table 16

Asthma Hospitalizations for Children, Rhode Island, 1998

CITY/TOWN	ESTIMATED NUMBER OF CHILDREN UNDER 18	NUMBER OF ASTHMA HOSPITALIZATIONS	RATE/1000 CHILDREN
Barrington	3,896	2	0.5
Bristol	4,317	11	2.5
Burrillville	4,215	5	1.2
Central Falls	4,603	6	1.3
Charlestown	1,795	6	3.3
Coventry	7,682	5	0.7
Cranston	14,079	19	1.3
Cumberland	6,338	5	0.8
East Greenwich	2,653	4	1.5
East Providence	10,351	14	1.4
Exeter	1,672	1	0.6
Foster	1,175	2	1.7
Glocester	2,257	1	0.4
Hopkinton	2,035	0	0.0
Jamestown	1,228	0	0.0
Johnston	5,294	2	0.4
Lincoln	3,918	5	1.3
Little Compton	701	0	0.0
Middletown	4,487	6	1.3
Narragansett	3,206	4	1.2
Newport	5,437	13	2.4
New Shoreham	178	0	NA
North Kingstown	6,809	3	0.4
North Providence	5,641	8	1.4
North Smithfield	2,088	2	1.0
Pawtucket	16,093	35	2.2
Portsmouth	4,387	6	1.4
Providence	37,195	146	3.9
Richmond	1,610	2	1.2
Scituate	2,635	0	0.0
Smithfield	3,958	11	2.8
South Kingstown	5,152	11	2.1
Tiverton	2,988	1	0.3
Warren	2,487	4	1.6
Warwick	18,811	27	1.4
Westerly	5,666	7	1.2
West Greenwich	1,147	1	0.9
West Warwick	6,696	9	1.3
Woonsocket	10,101	39	3.9
Unknown Residence	—	*1*	—
Core Cities	*73,429*	*239*	*3.3*
Remainder of State	*151,552*	*184*	*1.2*
Rhode Island	*224,981*	*424*	*1.9*

Source of Data for Table/Methodology

Rhode Island Department of Health, Hospital Discharge Database, 1998. Data are for Fiscal Year 1998, from July 1, 1997 to June 30, 1998. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is the total number of children under age 18 in 1999 according to GeoLytics estimates using data from the U.S. Bureau of the Census, 1990 Census of Population.

See methodology on page 96 for additional information on GeoLytics estimates.

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Additional Children's Health Issues

Rhode Island KIDS COUNT is dedicated to providing a comprehensive profile of the well-being of children in Rhode Island. However, there are some important issues affecting children for which there is a lack of available city and town data. Some of these critical health issues are as follows:

Children's Mental Health

◆ Many children are affected by mental health problems. Studies show that at any given time, at least 1 in 5 children and adolescents may have a mental health problem. In addition, 1 in 20 children may have a serious emotional disturbance.[1]

◆ Mental health professionals emphasize early intervention in order to keep children's emotional problems from intensifying. Children with mental health problems are found in all areas of children's services, including education, health, child welfare, and juvenile justice. Multi-agency planning for coordinated care is critical. The Rhode Island Child and Adolescent Services System Program (CASSP) promotes local systems of care that are family-focused, multi-disciplinary, and tailor individual support services to meet the needs of the child and family.

◆ In 1999, Rhode Island's eight Community Mental Health Centers provided services to a total of 6,885 children and youth.[2] Butler Hospital provided services to an additional 1,265 children and youth in its outpatient and partial hospital programs. During the same period, Butler Hospital admitted 900 children and youth, 43% of whom were diagnosed with depressive disorder.[3] Bradley Hospital, Rhode Island's largest psychiatric center for children and adolescents, admitted 912 children and youth to its hospital programs for the treatment of emotional disorders in 1999.[4]

References

[1] *Children's and Adolescents' Mental Health* (May 1996). [Fact Sheet]. Washington, DC: U.S. Department of Health and Human Services.

[2] Rhode Island Community Mental Health Centers, July 1, 1998 through June 30, 1999.

[3] Butler Hospital, July 1, 1998 through June 30, 1999.

[4] Bradley Hospital, July 1, 1998 through June 30, 1999.

Child Immunizations

◆ Children need to be immunized on schedule to guard against a variety of preventable diseases. It is estimated that every one dollar spent on immunizations saves ten dollars in later medical costs.[1]

◆ The 1998 National Immunization Survey conducted by the Centers for Disease Control shows that 80% of U.S. children ages 19 to 35 months were immunized.[2]

◆ In 1998, Rhode Island's immunization rate for 19 to 35 month-olds was 87%. Rhode Island ranked fifth best in the nation.[3]

◆ Children with family incomes below the poverty level are less likely to receive the combined series of immunizations than children with family incomes at or above the poverty level.[4]

◆ Retrospective surveys conducted by the Rhode Island Department of Health reveal significant discrepancies in the completeness of immunizations between children in low-income communities and the rest of the state. These discrepancies appear as early as three months of age, widen by seven months, and persist throughout the first two years of life.[5]

◆ Efforts to raise immunization rates include collaboration with WIC sites and health centers, free immunization walk-in clinics, and the development of KIDSNET, which includes a statewide system to remind parents and health care providers that inoculations are due.[6]

References

[1] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation of New York.

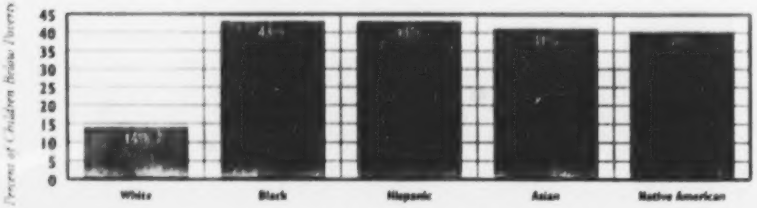
[2,3] *National Immunization Survey* (1998). Atlanta: Centers for Disease Control and Prevention.

[4] National Center for Health Statistics (1998). *Health, United States, 1998 with Socioeconomic Status and Health Chartbook*. Hyattsville, MD: U.S. Department of Health and Human Services.

[5,6] Rhode Island Department of Health, Immunization Program, 1999.

Racial and Ethnic Disparities in Child Health Outcomes

Children in Poverty, by Race and Ethnicity, Rhode Island, 1997



Note: Percentages are calculated within each race or ethnic group.

◆ More than three-quarters of Rhode Island's poor children are white, yet Black, Hispanic, Asian, and Native American children are three times as likely to be living in poverty. In Rhode Island, 14% of white children are poor and more than 40% of Black, Hispanic, Asian and Native American children are poor.[1]

◆ Minority children are more likely to live in families with incomes below the poverty line, more likely to have a parent that has not graduated from high school, and less likely to have health insurance and a regular source of medical care.[2]

◆ In 1997, there were 39,140 poor children in Rhode Island. Of these, 6,190 were Black, 10,039 were Hispanic, 609 were Native American, and 2,526 were Asian.[1]

◆ In 1996 in Rhode Island, 9% of white adults were uninsured as compared with 18% of blacks, 24% of Hispanics, and 23% of Asians.[4] Comparable data for children in Rhode Island are not available. Nationally, Hispanic children and poor children are the most likely to be uninsured.[5]

Child Health Outcomes, by Race and Ethnicity, Rhode Island, 1997

	WHITE	BLACK	HISPANIC	ASIAN	ALL RACES
Women with Delayed Prenatal Care	8.5%	18.5%	14.7%	15.9%	9.6%
Births to Teens Ages 15-17 (per 1,000 teens)	25	83	99	65	29
Infants Born Low Birthweight	6.5%	11.5%	7.9%	7.9%	7.0%
Infant Mortality Rate (per 1,000 live births)	5.5	10.1	7.9	6.1	6.4
Kindergarten Children with High Lead Levels (>=10ug/dL)	9%	30%	25%	33%	14%
Children Hospitalized for Asthma (per 1,000 children)	1.2	3.9	2.8	2.5	1.9

Source: Rhode Island Department of Health. Calculations by Rhode Island KIDS COUNT.

◆ Despite progress over the past decade, significant disparities in health outcomes continue to exist between minority children and white children in Rhode Island and across the United States.[6,7] Poor health interferes with a child's quality of life, educational opportunity, and future earning potential.[8]

◆ In Rhode Island, minority women are less likely to receive early prenatal care and more likely to give birth as teens. Black, Hispanic, and Asian children are more likely to be born low birthweight, to die in the first year of life, to suffer from lead exposure, and/or to be hospitalized for asthma.[9]

References

U.S. Bureau of the Census, Current Population Survey, 1995-1999 average.

Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin (September 1998). Washington, DC: Council of Economic Advisors for the President's Initiative on Race.

Rhode Island Department of Health, Office of Health Statistics. *Rhode Island Health Interview Survey*, 1996.

U.S. Census Brief (1998). "Children without Health Insurance." Washington, DC: U.S. Bureau of the Census.

Rhode Island Department of Health: Office of Family Health (prenatal care, teen births, low birthweight, infant mortality); Office of Occupational and Radiological Health (lead exposure); and Hospital Discharge Database (asthma hospitalizations). Calculations by Rhode Island KIDS COUNT.

Safety

Quiet Girl

I would liken you
To a night without stars
Were it not for your eyes.
I would liken you
To a sleep without dreams
Were it not for your songs.

–Langston Hughes

Child Deaths

DEFINITION

Child deaths are the number of deaths from all causes to children ages 1 to 14, per 100,000 children. The data are reported by place of residence, not place of death.

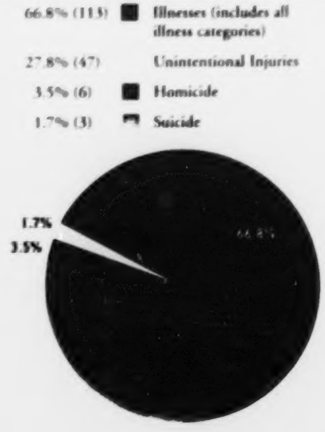
SIGNIFICANCE

The child death rate is a reflection of the physical health of children, the dangers to which children are exposed at home and in the community, and the level of adult supervision children receive.[1] Rhode Island has the lowest child death rate in the country.[2]

Unintentional injury is the single leading cause of death for children ages 1 to 14 in Rhode Island and nationally.[3,4] Of the 169 child deaths in Rhode Island between 1994 and 1998, more than one-quarter (28%) were due to unintentional injuries.[5] This percentage is higher than for any specific illness category. Between 1994 and 1998 there were 56 deaths due to injuries among Rhode Island children ages 1 to 14.[6] Of these injury deaths, nearly half (22) were caused by fire and car accidents.[7]

The child death rate due to unintentional injuries is an underestimate of the impact of unintentional injuries on child health. For every childhood death caused by injury, there are 34 hospitalizations, 1,000 emergency department visits, many more visits to private physicians and school nurses, and an even larger number of injuries treated at home. Nationally, 20-25% of all children sustain an injury severe enough to require medical attention, missed school, and/or bed rest.[8] Many of the injuries that do not result in death leave children temporarily or permanently disabled, result in time lost from school, and decrease the child's ability to participate in everyday activities.[9]

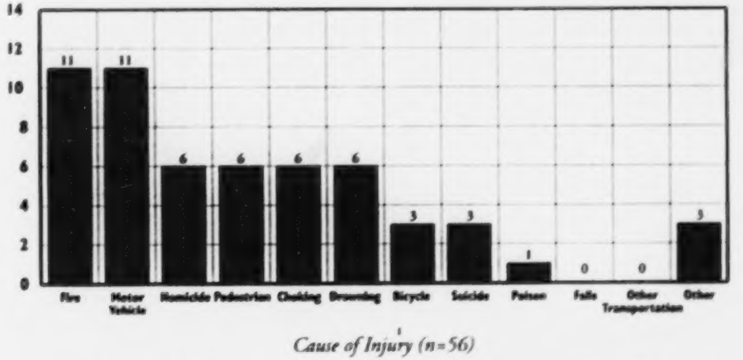
Child Deaths by All Causes, Children Ages 1 to 14, Rhode Island, 1994-1998



n=169

Source: Rhode Island Department of Health, Maternal and Child Health Database, 1994-1998.

Cause of Injury Deaths, Children Ages 1 to 14, Rhode Island, 1994-1998



Source: Rhode Island Department of Health, Maternal and Child Health Database, 1994-1998. Data for 1996-1998 are provisional.

Risk Factors for Childhood Injury

◆ Unintentional injuries disproportionately affect poor children, young children, males, and minorities. Black children have the highest death rate of any ethnic group. In the U.S., the death rate for black children ages 1 to 4 is twice that for white children.[10]

◆ Factors that may increase a child's risk of injury include lack of education, young maternal age, multiple siblings, dilapidated housing, and unsafe play areas.[11]

◆ The vast majority of unintentional injury-related deaths among children occur in the evening hours when children are most likely to be out of school and unsupervised.[12]

◆ Motor vehicle accidents are a leading cause of injury deaths to children ages 1 to 14 in Rhode Island and nationally. Two-thirds of the motor vehicle occupants 0-14 years old who are killed in fatal crashes are unrestrained (i.e. infants and young children who are not in properly installed car seats and older children whose seatbelts are not fastened).[13]

Table 17

Child Deaths, Rhode Island, 1994-1998

CITY/TOWN	NUMBER OF CHILDREN AGES 1-14	NUMBER OF CHILD DEATHS	RATE PER 100,000
Barrington	15,695	3	NA
Bristol	17,025	5	NA
Burrillville	17,930	2	NA
Central Falls	19,300	3	NA
Charlestown	6,455	0	NA
Coventry	30,045	4	NA
Cranston	57,505	3	NA
Cumberland	25,320	2	NA
East Greenwich	11,450	0	NA
East Providence	42,160	13	NA
Exeter	6,045	2	NA
Foster	4,745	2	NA
Glocester	10,145	1	NA
Hopkinton	7,445	1	NA
Jamestown	4,485	1	NA
Johnston	20,835	4	NA
Lincoln	15,265	2	NA
Little Compton	2,930	0	NA
Middletown	19,030	0	NA
Narragansett	11,390	2	NA
Newport	22,730	1	NA
New Shoreham	675	0	NA
North Kingstown	24,270	4	NA
North Providence	21,615	7	NA
North Smithfield	8,920	1	NA
Pawtucket	65,495	12	NA
Portsmouth	16,315	4	NA
Providence	151,095	38	NA
Richmond	6,345	4	NA
Scituate	9,390	1	NA
Smithfield	15,515	5	NA
South Kingstown	19,180	0	NA
Tiverton	12,140	3	NA
Warren	9,610	3	NA
Warwick	71,880	12	NA
Westerly	20,030	6	NA
West Greenwich	3,635	1	NA
West Warwick	25,840	7	NA
Woonsocket	42,310	10	NA
Core Cities	*300,930*	*64*	*21.3*
Remainder of State	*591,260*	*105*	*17.8*
Rhode Island	*892,190*	*169*	*18.9*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, 1994-1998. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls. Data for 1996-1998 are provisional.

NA: Because nearly all cities have a low number of deaths, the death rates are highly variable, and therefore the rates are not provided for cities and towns.

The denominator is the number of children ages 1 to 14 according to the 1990 Census of Population, multiplied by five to compute a rate over five years, 1994-1998.

References for Indicator

[1] *A Data Book of Child and Adolescent Injury* (1991). Washington, DC: Childrens Safety Network.

[2] *KIDS COUNT Data Book: State Profiles of Child Well-Being 1999* (1999). Baltimore, MD: The Annie E. Casey Foundation.

[3,4,5] Rhode Island Department of Health, Maternal and Child Health Database, 1994-1998. Data for 1996-1998 are provisional.

[6] National Center for Health Statistics (1998). *Health, United States, 1998 With Socioeconomic Status and Health Chartbook.* Hyattsville, MD: US Department of Health and Human Services.

[7] "Unintentional Injury Factsheet" (1999). Washington, DC: National Center for Injury Prevention and Control.

[8] Lewit, E. M. and Schuurman Baker, L.,"Unintentional Injuries" in *The Future of Children*, Vol. 5, Number 1 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[9] *America's Children: Key Indicators of Well-Being (1999).* Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[10,11] "Childhood Injury Fact Sheet" (1997). Washington, DC: National Safe Kids Campaign.

[12] "Unintentional Injury Factsheet: Child Passenger Safety" (1999). Washington, DC: National Center for Injury Prevention and Control.

Teen Deaths

DEFINITION

Teen deaths are the number of deaths from all causes to teens ages 15 to 19, per 100,000 teens. The data are reported by place of residence, not place of death.

SIGNIFICANCE

The transition to adulthood confronts teens of all ages with health and safety risks. Teens are more likely than any other age group to take risks that can cause injury to themselves or others. Factors contributing to teen deaths include risk-taking behavior, the use of alcohol and drugs, and violence.[1]

The 1996 national teen death rate of 78.6 was nearly twice that of Rhode Island.[2] Nationally, the two leading causes of death for teens ages 15 to 19 are motor vehicle traffic accidents and firearm deaths.[3] Between 1985 and 1995, the risk of dying from a firearm injury more than doubled for U.S. teenagers 15 to 19 years of age.[4] In Rhode Island between 1994 and 1998, the two leading causes of teen death were motor vehicle accidents and homicide.[5]

Forty percent of Rhode Island teen deaths are due to unintentional injuries. Of the 58 teen deaths due to unintentional injuries between 1994 and 1998, 57% were due to motor vehicle collisions.[6] The *1997 Youth Risk Behavior Survey* found that — during the thirty days preceding the survey — *only 24% of the teens had always used* safety-belts when riding in a car; 36% had driven with someone who had been drinking alcohol; and 33% of 12th graders had driven a car when they had been drinking alcohol.[7]

More than one-quarter (27%) of the deaths among Rhode Island teens are due to intentional injuries (i.e. homicide or suicide). Homicide and suicide claimed the lives of 39 teens between 1994 and 1998.[8] Nationally, males ages 15 to 19 are five times more likely to die of homicide or suicide than females.[9]

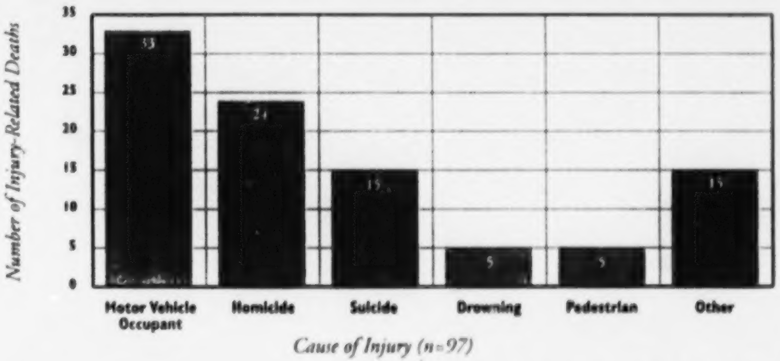
Gun Deaths
Teens* Ages 15 to 19, Rhode Island, 1990-1998

YEAR	NUMBER OF DEATHS
1990	4
1991	9
1992	3
1993	8
1994	5
1995	6
1996	3
1997	4
1998	5

**There were 10 gun deaths to children ages 5 to 14 during this time period.*

Source: National Center for Health Statistics, Vital Statistics (1998). *Rhode Island Mortality Statistics, 1989-1994.* Rhode Island Department of Health, Office of Health Statistics, 1993-1998.

Cause of Injury Deaths, Teens Ages 15 to 19, Rhode Island, 1994-1998



◆ Between 1994 and 1998, the leading causes of death due to injuries for Rhode Island teens ages 15 to 19 were motor vehicle accidents (33 deaths), homicide (24 deaths), and suicide (15 deaths). An additional 46 teen deaths were due to illnesses.

◆ In Rhode Island, the teen death rate from all causes dropped from 47.1 deaths per 100,000 teens in 1987-1991 to 40.4 deaths per 100,000 teens in 1994-1998. There were 182 teen deaths between 1987 and 1991 compared to 143 teen deaths between 1994 and 1998.

Source: Rhode Island Department of Health, Maternal and Child Health Database, 1994-1998. Data for 1996-1998 are provisional.

Gun-Related Hospitalizations, Rhode Island, 1994-1998

◆ In Rhode Island from 1994 to 1998, there were 110 children hospitalized with gunshot wounds. Of these, two of the victims were younger than age 5, four were between the ages of 5 and 9, twelve were between the ages of 10 and 14, and ninety-two were between the ages of 15 and 19. Sixty were intentional injuries, 41 were unintentional, and 9 were of undetermined intention.[10]

◆ Between 1994 and 1998, two-thirds (67%) of the 110 gun-related hospitalizations were Providence residents. Between 1996 and 1998, Providence gun-related injuries decreased 62% from 24 hospitalizations to 9 hospitalizations.[11]

Teen Deaths

Table 18

Teen Deaths, Rhode Island, 1994-1998

CITY/TOWN	NUMBER OF TEENS AGES 15-19	NUMBER OF TEEN DEATHS	RATE PER 100,000
Barrington	5,020	0	NA
Bristol	9,705	2	NA
Burrillville	5,660	1	NA
Central Falls	5,740	2	NA
Charlestown	1,640	2	NA
Coventry	10,695	6	NA
Cranston	21,325	14	NA
Cumberland	9,070	2	NA
East Greenwich	4,040	6	NA
East Providence	14,630	3	NA
Exeter	1,750	1	NA
Foster	1,445	1	NA
Glocester	3,535	1	NA
Hopkinton	2,290	0	NA
Jamestown	1,420	0	NA
Johnston	7,660	2	NA
Lincoln	5,540	3	NA
Little Compton	1,010	1	NA
Middletown	5,650	0	NA
Narragansett	3,910	3	NA
Newport	11,140	5	NA
New Shoreham	125	0	NA
North Kingstown	7,970	1	NA
North Providence	8,705	1	NA
North Smithfield	3,610	1	NA
Pawtucket	22,435	7	NA
Portsmouth	5,310	1	NA
Providence	72,915	35	NA
Richmond	1,815	2	NA
Scituate	3,430	0	NA
Smithfield	9,240	11	NA
South Kingstown	20,300	4	NA
Tiverton	5,020	0	NA
Warren	3,120	3	NA
Warwick	26,290	9	NA
Westerly	6,150	4	NA
West Greenwich	1,295	0	NA
West Warwick	8,990	5	NA
Woonsocket	14,710	4	NA
Core Cities	*126,940*	*53*	*41.8*
Remainder of State	*227,365*	*90*	*39.6*
Rhode Island	*354,305*	*143*	*40.4*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, 1994-1998. Data for 1996-1998 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

Because nearly all cities have a low number of deaths, the death rates are highly variable, and therefore the rates are not provided for cities and towns.

The denominator is the number of teens ages 15 to 19 according to the 1990 Census of Population, multiplied by five to calculate a rate over five years, 1994-1998.

References for Indicator

[1] *Losing Generations: Adolescents in High Risk Settings* (1993). Washington, DC: National Academy Press.

[2] *National Vital Statistics Report* (1998). Vol. 47, No. 9, November 10, 1998. Atlanta, GA: Centers for Disease Control and Prevention.

[3] *America's Children: Key National Indicators of Well-Being* (1999). Washington, DC: Interagency Forum on Child and Family Statistics.

[4] Centers for Disease Control (1999). *Firearm Injuries and Fatalities.* Atlanta, GA: National Center for Injury Prevention and Control.

[5,6,7] Rhode Island Department of Health, Maternal and Child Health Database, 1994-1998.

[8] *1997 Rhode Island Youth Risk Behavior Survey* (1998). Providence, RI: Rhode Island Department of Health.

[9] Centers for Disease Control (1999). *Facts on Adolescent Injury.* Atlanta, GA: National Center for Injury Prevention and Control.

[10,11] Rhode Island Department of Health, Hospital Discharge Database, 1994-1998.

Homeless Children

DEFINITION

Homeless children is the number of Rhode Island children under 13 years old who received emergency housing services at emergency homeless shelters and domestic violence shelters between July 1, 1998 and June 30, 1999.

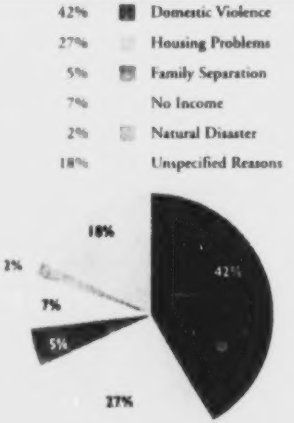
SIGNIFICANCE

Poverty and lack of affordable housing are factors in family homelessness.[1,2] The shortage of affordable apartments and the dwindling number of housing subsidies have caused many Rhode Island families to "double-up", resulting in overcrowded, unstable living conditions. With a large percentage of family income going toward rent, any interruption in income or unexpected expense can place families at risk of homelessness.[3,4]

In the U.S., more than 40% of the homeless are women and children — the fastest growing homeless group.[5] Homelessness severely affects the health and well-being of all family members. Stable housing is a basic necessity if a person is going to be productive at work or school. Transience makes it difficult or impossible to obtain and keep a job. Infants, toddlers and preschoolers who are homeless develop more slowly and may develop emotional problems serious enough to require professional care.[6] Children may find it difficult to develop supportive relationships with adults or peers when their lives are disrupted by temporary moves.

In Rhode Island in 1999, there were 994 children who received shelter from the emergency and domestic violence shelter system: 564 (57%) were age 5 or under, 355 (36%) were ages 6 to 12, and 75 (8%) were ages 13 to 17.[7] Nearly 85% were in single parent families. Nearly two-thirds of the families receiving shelter had incomes below $15,000 and one-third had no income at all.[8]

Reasons Families Needed Shelter, Rhode Island, 1999



n=803 families

**Housing problems includes housing costs, legal evictions, relocations, landlord/tenant disputes, and utilities shut-off*

Source: *RI Emergency Shelter Information Project Annual Report*, July 1, 1998 – June 30, 1999 (2000). Providence, RI: RI Emergency Food and Shelter Board

Homelessness Affects Children's Health and Education

◆ Deprived of the protection and stability a home provides, homeless children have substantially higher levels of acute and chronic illness. They suffer twice as many ear infections, five times more diarrhea and stomach problems, and are four times more likely to have asthma than other children.

◆ Nearly 20 percent of homeless children lack a regular source of medical care. One third of homeless children lack essential immunizations and one third have never been screened for lead poisoning.

◆ Due to frequent moves and the stress of shelter life, homeless children often suffer from emotional distress. They have more pronounced worries and fears than other children, and are more likely to have serious emotional problems such as anxiety, depression, withdrawal, severe aggression and hostility. Despite higher rates of mental health problems, less than one-third of homeless children receive treatment.

◆ Periods of homelessness, or a rapid succession of moves due to an unstable living situation have a negative effect on a child's education. Homeless children are more likely to repeat a grade and to be suspended. Although homeless children are more likely to be learning disabled, they are less likely to be treated for their learning disabilities and less likely to receive special education services.

◆ In 1999, the Better Homes Fund ranked Rhode Island 18th in the U.S. for children at risk of homelessness based on a list of factors. These factors are: the percentage of families living in extreme poverty, foster care rates, children in households with worst case housing need, number of female-headed households, the vacancy rate for affordable housing, the number of school-age homeless children, and the rate of decrease in welfare case loads.

Source: *Homeless Children: America's New Outcasts* (1999). Newton, MA: The Better Homes Fund

DEFINITION

Homeless youth is the number of Rhode Island youth ages 13 to 21 who are homeless or at risk of homelessness, have run away from home, or have been thrown out of their home and not allowed to return.

SIGNIFICANCE

Many homeless and runaway youth are fleeing disruptive and abusive family conditions.[9] Some runaway youth are considered to be "throw-aways" who were told to leave a household, were abandoned or deserted, or tried to return home and were denied access.[10] Homeless youth are at risk of being physically and/or sexually victimized, abusing drugs and alcohol, attempting suicide, becoming victims or perpetrators of crime, receiving money for sex to meet their basic survival needs, and contracting HIV/AIDS.[11]

Adolescents who have supportive relationships with their parents, their families, other caring adults, and their school community are healthier and less likely to be involved in high-risk situations than those who lack such supportive relationships. This "connectedness" is a protective factor in the lives of teens regardless of their race, ethnicity, family structure, or poverty status.[12]

Homeless/Runaway/Throwaway Youth in Rhode Island

Emergency Shelter System

◆ There were 75 youth between the ages of 13 and 17 who received shelter through the emergency shelter system in Rhode Island between July 1998 and June 1999.[13] This is an underestimate of the number of youth in need of shelter, as many of the emergency and domestic violence shelters do not accept males over the age of twelve.

Travelers Aid

◆ While there are no accurate data on the total number of homeless and runaway youth in Rhode Island, there has been a steady increase in the number of homeless youth served by Travelers Aid.[14] Rhode Island does not have an overnight emergency shelter for runaway youth.

◆ A total of 975 youth under age 22 accessed services through Travelers Aid from January through December 1999. Of these, 253 were homeless, 326 were runaways/throwaways (under age 18), and 248 were in transitional arrangements, including treatment centers, shelters, or "doubled up" with family members. The remainder (148) were considered to be at-risk for homelessness.[15]

◆ Of the youth that received services in 1999 from Travelers Aid, over half had dropped out of school; 40% were uninsured; 60% were either presently or had in the past been involved with DCYF; and 13% of the youth had children themselves.[16]

◆ In 1999, the Travelers Aid Runaway Youth Project provided street outreach services in Providence, Pawtucket, Central Falls and Newport to 5,715 youth at-risk for homelessness or who were homeless/runaways.[17]

DCYF Night-to-Night Placements and Unauthorized Absence

◆ In 1999, an average of 20 teen boys and 40 teen girls per month were in "night-to-night placements." Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting a permanent foster care placement, a group home/treatment placement, or who have run away from their current placement.[18]

◆ As of December 1999, there were 114 youth in DCYF care who were classified as unauthorized absence/runaways.[19]

References for Indicators

Homeless Children

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[illegible] *Homeless Children: America's New Outcasts* (1999). Newton, MA: The Better Homes Fund.

[illegible] *Children and Their Housing Needs: A Report to KIDS COUNT* (1993). Washington, DC: Center on Budget and Policy Priorities.

[illegible] Rhode Island Emergency Shelter Information Project, July 1, 1998-June 30, 1999 (2000). Providence, RI: RI Emergency Food and Shelter Board.

Homeless Youth

[9,11] *Youth with Runaway, Throwaway, and Homeless Experiences: Prevalence, Drug Use, and Other At-Risk Behaviors* (1995). FYSB Update. Washington, D.C.: Family and Youth Service Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

[10] Schneider, D. (1995). *American Childhood: Risks and Realities.* New Jersey: Rutgers University Press.

[12] Blum, R.W., & Rinehart, P.M. (1997). *Reducing the Risk: Connections that Make a Difference in the Lives of Youth.* Minneapolis, MN: University of Minnesota, Division of General Pediatrics and Adolescent Health.

[13] Rhode Island Emergency Shelter Information Project, July 1, 1998-June 30, 1999 (2000). Providence, RI: The Rhode Island Emergency Food and Shelter Board.

[14,15,16,17] Travelers Aid. Providence, RI. Year-End Reports, 1995, 1996, 1997, 1998, 1999.

[18] Rhode Island Department of Children, Youth and Families, December 1999.

[19] Rhode Island Office of the Child Advocate, December 1999.

Juveniles Referred to Family Court

DEFINITION

Juveniles referred to Family Court is the percentage of youth ages 10 to 17 referred to Rhode Island Family Court for all wayward and delinquent offenses.

SIGNIFICANCE

Poor school performance, including chronic truancy and falling behind one or more grade levels, increases the likelihood of involvement with the juvenile justice system. Other risk factors for juvenile crime and delinquency include poverty, family violence, inadequate supervision, limited education and job skills, substance abuse, and mental health problems.[1,2,3] Most juvenile crime takes place in the after-school and early evening hours.[4]

The Rhode Island Family Court has jurisdiction over all juvenile offenders referred for wayward and delinquent offenses. All referrals to Family Court are from state and local law enforcement agencies, except for truancy cases which are referred by local school departments. Approximately one-third of all cases referred to Family Court are diverted instead of proceeding to a formal court hearing. In 23 communities, a Juvenile Hearing Board allows juvenile offenders to bypass the formal court process when they are willing to admit their offense. Juvenile diversion options include community service, restitution, mental health or substance abuse counseling, and/or a community-based program. According to Rhode Island Family Court, community-based diversion programs, rehabilitation options, and community-based placements are not available to all youth who need them.

The best prevention strategies for most adolescent risk behaviors (including crime and substance abuse) enable youth to develop caring, supportive relationships within their families, schools, peer groups, and community. Effective programs focus on truancy reduction, substance abuse services, youth mental health services, mentoring, conflict resolution, after-school tutoring, vocational training, recreation, community service and leadership development.[5,6,7] Programs are most effective when they are comprehensive, community-based, culturally-appropriate and initiated early in a child's development.[8]

Rhode Island is one of six states participating in the U.S. Justice Department Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Comprehensive Strategy which is designed to improve the effectiveness of the juvenile justice system; provide appropriate prevention methods to children, families, and communities; and, intervene in the lives of first-time offenders with structured programs and services.[9]

Juvenile Wayward/Delinquent Offenses Referred to Family Court, by Type of Offense, Rhode Island, 1999

33%	**Property Offenses**	5%	**Violent Crime Offenses**
16%	**Status Offenses***	5%	**Traffic Offenses**
12%	**Disorderly Conduct**	2%	**Weapons Offenses**
11%	**Simple Assaults**	5%	**Other****
11%	**Alcohol and Drugs**		

n = 7,901

**Status Offenses are age-related acts that would not be punishable if the offender were an adult, such as truancy and disobedient conduct.*

***Other includes offenses such as false fire alarms, conspiracy, aiding and abetting, crank/obscene phone calls, and sex offenses other than rape.*

◆ In 1999, there were 4,402 juveniles referred to Family Court for 7,901 offenses. Since 1998, the number of juveniles referred to Family Court has decreased by 6% (from 4,700 juveniles in 1998 to 4,402 in 1999); the number of offenses has decreased by 15% (9,272 offenses in 1998 versus 7,901 in 1999).

◆ Between 1988 and 1999, the percentage of Rhode Island youths ages 10 to 17 who were referred to Family Court increased from 3.4% to 4.6%.

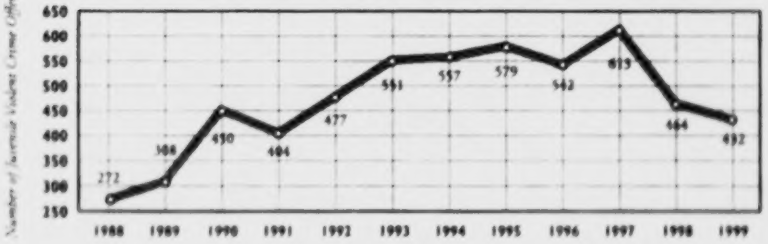
Source: Rhode Island Family Court, 1988, 1998 and 1999 Juvenile Offense Reports.

Rhode Island's Juvenile Drug Court

◆ Juveniles who commit crimes involving drugs may be referred by the Family Court to the Juvenile Drug Court, rather than proceeding through the regular juvenile court system. Drug Court participants have offenses ranging from possession of marijuana to possession of heroin and have used drugs an average of three times per week.[10]

◆ The focus of the Juvenile Drug Court is treatment and rehabilitation. Juveniles referred to the Drug Court undergo a six to twelve month program that includes intensive court supervision, drug treatment, school performance reviews, job placement, and development of social skills and interests outside the drug culture.[11]

Juvenile Violent Crime in Rhode Island, 1988 to 1999



◆ The juvenile violent crime rate increased from the late 1980s to the late 1990s, peaking in 1997. The juvenile violent crime rate began to decline in 1998 and in 1999 was at its lowest level since 1991.[12]

◆ Between 1990 and 1999, violent crime offenses accounted for 5.3% of all offenses for youth ages 10 to 17.[13]

◆ The core cities of Providence, Pawtucket, Woonsocket, Newport and Central Falls accounted for 57% of all juvenile violent crime in 1999 and for 42% of all juveniles referred for any offense. The juvenile crime rate, including the rate for violent crimes, decreased in the core cities between 1997 and 1999.[14]

Juveniles Tried as Adults

◆ In 1999, the Attorney General's Office filed 30 motions for waiver of jurisdiction to try juveniles as adults, one automatic certification and two drug certifications. Fourteen of these motions were granted; three were certified; eight were withdrawn to the Rhode Island Training School, one discretionary waiver was dismissed; and seven are pending.[15]

The Rhode Island Training School for Youth

◆ The Department of Children, Youth, and Families operates the Rhode Island Training School for Youth, the state's 174-bed residential detention facility for adjudicated youths and those awaiting trial.

◆ As of December 1, 1999, there were 186 youths at the Training School, which is 7% over capacity. During 1999, a total of 1,157 youth passed through the Training School.[17]

◆ The Training School population ranges in age from 10 to 22; the average age is 16.8 years; 90% of the residents are male. Two-thirds of the youth at the Training School are ethnic or racial minorities.[18]

◆ The mean reading level of the total Training School population is fifth (5.8) grade; and the mean mathematics level is fifth (5.5) grade. A survey of educational records of Training School youth confirms significant academic difficulty. Based on 42 records reviewed, only 12 youth were attending school one year prior to detention/adjudication and had passing grades.[19]

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[17,18,19] Superintendent's Office, RI Training School for Youth, January 1999.

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Children and Domestic Violence

DEFINITION

Children and domestic violence is the percentage of reported domestic violence incidents in which children under age 18 were present in the home. The data are based on police reports of domestic violence in 1998. Domestic violence is the use of physical force, or threat of force, against a current or former partner in an intimate relationship, resulting in fear and emotional and/or physical suffering.

SIGNIFICANCE

Domestic violence is a serious social issue that affects all communities and cuts across racial, ethnic and economic lines.[1] It is estimated that one-fifth to one-third of all women are assaulted by a partner or ex-partner during their lifetime.[2] In Rhode Island in 1998, police reports indicate that children were present in 39% of domestic violence incidents reported.[3] National surveys of mothers indicate that 87% of children have witnessed the abuse in homes where there is domestic violence.[4]

Children who experience adult domestic violence in their homes suffer trauma even if they, themselves, are not physically harmed. Children may experience violent events in the home in several ways. They may witness their mother being abused, hear their mother's cries or a batterer's threats, and/or observe the results of a violent event through their mother's injuries or broken furniture.[5]

Exposure to domestic violence can limit children's cognitive development and their ability to form close attachments.[6] Children who witness domestic violence experience anxiety, fear, sleep disruption, depression, post-traumatic stress disorder, and have problems in school.[7,8] Children who experience violence over a period of time are more likely to have serious emotional and behavioral problems, including violent behavior.[9]

Children who grow up in violent homes are much more likely to become abusive partners or victims of abuse in adulthood. Over 80% of abusive partners had themselves either been victims of child abuse or had witnessed their mothers being abused.[10] Children in homes where a parent is abusive to a spouse are at increased risk of child abuse. More than half of men who abuse their female partners also abuse their children.[11]

There are six shelter and advocacy programs in Rhode Island that offer services to children who witness domestic violence. Services include group therapy, individual counseling, expressive arts therapy, and child care. In 1999, the six domestic violence agencies provided services to 1,335 Rhode Island children; of these, 387 children spent time in a domestic violence shelter.[12]

The Effects of Family Violence on Children

Infants

◆ Have a propensity to illness, irritability and sleep problems.

◆ May experience separation anxiety because the victim of abuse may have difficulty addressing their needs.

◆ May be injured in a battering incident if they are caught between parents.

Toddlers

◆ May feel responsible for the violence. May be open to discuss their feelings.

◆ May be reluctant to leave their mother, fear being alone, and regress to earlier stages of development.

Elementary School Age Children

◆ May suffer from emotional problems, including a sense of shame and guilt out of a belief that they should be able to prevent the violence.

◆ Boys learn that violence is an appropriate way to resolve conflict. They are often disruptive and act aggressively toward people and objects.

◆ Girls may learn that victimization is inevitable. They are likely to be withdrawn, passive and cling to their mother.

Teenagers

◆ May run away or may feel that they cannot leave home because they must protect their mother or younger siblings.

◆ May engage in delinquent behavior and become involved with the juvenile justice system.

◆ Boys may become abusive in their dating relationships or may model their abusive parent's behavior toward their mother or sisters.

◆ Girls may accept threats and violence from boyfriends.

Source: Wilson, K.J. (1997). "The Effects of Family Violence on Children," in *When Violence Begins at Home*. Alameda, CA: Hunter House Publications.

Children and Domestic Violence in Rhode Island

◆ Based on police reports from cities and towns in Rhode Island between January 1, 1998 and December 31, 1998, children were present during 2,573 (39%) of the 6,541 reported cases of domestic violence. An additional 87 incidents were reported to state police; police reported that children were present at 33 of these incidents.[13]

◆ Police officers reported that in 1,711 incidents the children saw their parent being abused and in 2,067 incidents the children heard their parent being abused. These numbers are based on police reports in which the attending officer may check any combination of three boxes: "Were children present during the incident?" "Did children witness the incident?" "Did children hear the incident?"[14]

◆ Table 19 underrepresents the number of incidents of domestic violence in which a child was present because police reports are not fully completed in all cases. Additionally, many cases of domestic violence are never reported to police.

◆ Table 19 underestimates the total number of children who experienced domestic violence in their homes, since more than one child may be present at the incident.

Table 19.

Domestic Violence Incidents with Childr

CITY/TOWN	TOTAL NUMBER OF DOMESTIC VIOLENCE INCIDENT REPORTS	TOTAL INCIDEN A CHILD
Barrington	57	
Bristol	74	
Burrillville	70	
Central Falls	213	
Charlestown	22	
Coventry	193	
Cranston	396	
Cumberland	116	
East Greenwich	44	
East Providence	276	
Exeter	NA	
Foster	8	
Glocester	70	
Hopkinton	41	
Jamestown	5	
Johnston	290	
Lincoln	55	
Little Compton	16	
Middletown	176	
Narragansett	116	
Newport	312	
New Shoreham	7	
North Kingstown	176	
North Providence	177	
North Smithfield	63	
Pawtucket	810	
Portsmouth	103	
Providence	603	
Richmond	23	
Scituate	31	
Smithfield	84	
South Kingstown	69	
Tiverton	65	
Warren	180	
Warwick	466	
Westerly	257	
West Greenwich	23	
West Warwick	290	
Woonsocket	564	
Core Cities	*2,502*	
Remainder of State	*4,039*	
Rhode Island	*6,541*	

Children and Domestic Violence

dents with Children Present, Rhode Island, 1998

BER OF OLENCE EPORTS	TOTAL NUMBER OF INCIDENTS IN WHICH A CHILD WAS PRESENT	% OF INCIDENTS WITH CHILDREN PRESENT
	28	49%
	32	43%
	24	34%
	93	44%
	8	36%
	60	31%
	151	38%
	42	36%
	17	39%
	121	44%
	NA	NA
	5	63%
	34	49%
	19	46%
	1	20%
	116	40%
	26	47%
	9	56%
	62	35%
	40	34%
	104	33%
	2	29%
	66	38%
	59	33%
	34	54%
	306	38%
	30	29%
	272	45%
	8	35%
	17	55%
	36	43%
	27	39%
	22	34%
	85	47%
	198	42%
	84	33%
	11	48%
	100	34%
	224	40%
	999	*40%*
	1,574	*39%*
	2,573	*39%*

Source of Data for Table/Methodology

The number of domestic violence incident reports and the number of incidents in which children were present are based on the Domestic Violence and Sexual Assault/Child Molestation Reporting Forms received by the Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit between January 1, 1998 and December 31, 1998.

References for Indicator

[1,4] *The Impact of Domestic Violence on Children: A Report to the President of the American Bar Association* (1994). Chicago: American Bar Association Center for Children and the Law.

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[5,13,14] Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit. Based on data from Domestic Violence and Sexual Assault/Child Molestation Reporting Forms received from police departments between January 1, 1998 and December 31, 1998.

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[16] The Rhode Island Coalition Against Domestic Violence. Data for the period from January 1, 1999 through December 31, 1999.

Child Abuse and Neglect

DEFINITION

Child abuse and neglect is the total number of indicated cases of child abuse and neglect per 1,000 children. "Indicated case" means that credible evidence exists that child abuse and/or neglect occurred following an investigation of an abuse report. An indicated case can involve more than one child. Child abuse includes physical, sexual, and emotional abuse. Child neglect includes physical, emotional, and medical neglect.

SIGNIFICANCE

Preventing child abuse and neglect is critical to helping children grow into strong, healthy, productive adults and good parents. Children are at increased risk for maltreatment if their parents or caregivers are overwhelmed by multiple problems such as inadequate income, lack of a job or a decent place to live, emotional stress, isolation from extended family or friends, drug and/or alcohol abuse, mental illness, or domestic violence.[1] Recent studies confirm that child abuse is linked to increases in dropout rates, juvenile delinquency, running away, substance abuse, suicide, criminal behavior, emotional disturbances, promiscuity, and teenage pregnancy.[2,3,4]

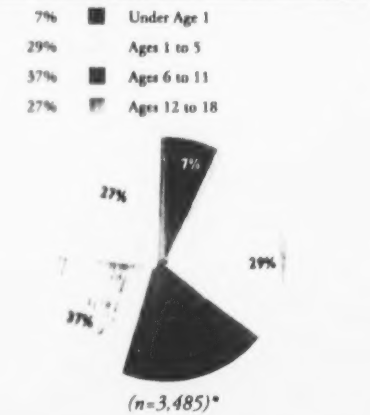
Many abusive parents lack essential parenting skills and are struggling with a combination of social and economic issues. Preventing child abuse and neglect requires help with housing, food, and child care as well as parenting education and counseling for substance abuse, domestic violence, and other problems. Families benefit from access to community-based, comprehensive services that are able to flexibly respond to their needs.[5,6]

An increasing number of children entering relative and non-relative foster care homes have significant emotional, behavioral and medical needs, including developmental delays, low birth weight, congenital diseases, and health problems due to prenatal drug exposure.[7] Current estimates indicate that between 50% and 80% of families involved with child protective services are dealing with a substance abuse problem.[8] The complex needs of the children require adequate support for foster parents and a comprehensive array of services and supports in the community.[9,10]

In 1999 in Rhode Island, 3,485 children were determined by DCYF to be victims of abuse and neglect. There were 608 children under the age of 3 who were abuse and neglect victims; of these, 236 were infants under the age of one.[11] Between July 1, 1998 and June 30, 1999, there were 24 children hospitalized with the diagnosis of child abuse or neglect.[12]

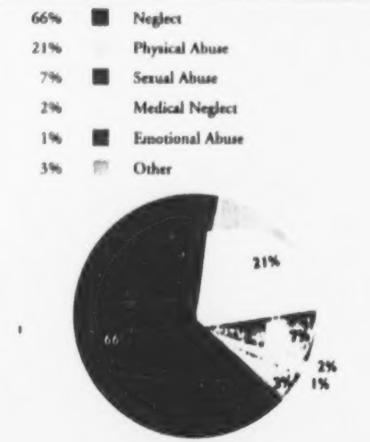
Indicated Cases of Child Abuse and Neglect, Rhode Island, 1999

By Age of Victim



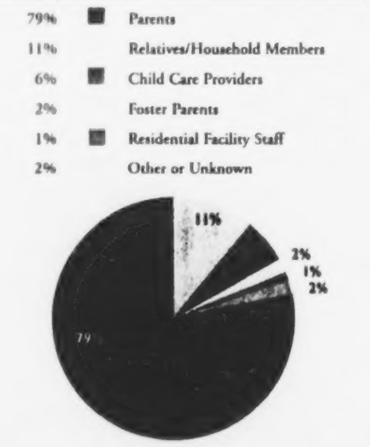
*(n=3,485)**

By Type of Abuse



*(n=4,416)***

By Relationship of Victim to Perpetrator



*(n=4,452)****

Notes on Pie Charts

All data are from the Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 1999. Numbers may not add to 100 due to rounding.

** The number of victims is higher than the number of indicated cases. One indicated case can involve more than one child victim. Data reflect an unduplicated count of child victims.*

***This number reflects maltreatment events, not children. Children often experience more than one type of abuse. For example, if a child were physically and sexually abused, two maltreatment events would be counted.*

****Perpetrators can abuse more than one child and can abuse a child more than once.*

DCYF (CANTS)* Hotline Calls for Reports of Abuse and/or Neglect, Investigations, and Indicated Cases, Rhode Island, 1994-1999

YEAR	TOTAL NUMBER UNDUPLICATED CHILD MALTREATMENT REPORTS	NUMBER OF COMPLETED INVESTIGATIONS**	NUMBER OF INDICATED CASES
1994	13,968	8,478	2,732
1995	13,841	8,553	2,781
1996	13,098	8,398	2,541
1997	12,437	8,485	2,577
1998	12,674	8,463	2,459
1999	13,519	7,882	2,628

◆ In 1999, DYCF received 13,519 calls to the Rhode Island Child Abuse Hotline (1-800-RI-CHILD); completed 7,882 investigations of child abuse reports; and determined that there were 2,628 indicated cases in which credible evidence existed that child abuse and/or neglect occurred.

◆ In 1999, the average number of families per DCYF caseworker was 14; and the average number of children per caseworker was 23.

* *Child Abuse and Neglect Tracking System*

** *One CANTS investigation can be generated by multiple hotline calls*

Source: All data are from the Rhode Island Department of Children, Youth and Families.

Rhode Island Child Deaths Due to Child Abuse and/or Neglect*

YEAR	NUMBER OF DEATHS	YEAR	NUMBER OF DEATHS
1990	4	1995	5
1991	7	1996	4
1992	4	1997	2
1993	3	1998	3
1994	5	1999	3
		1990-1999 Total	*40*

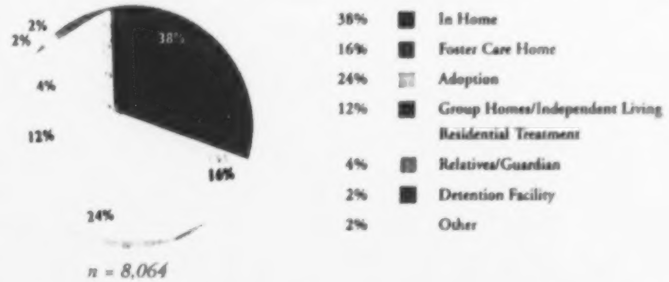
◆ Between 1990 and 1999, forty children died as a result of injuries due to abuse by a parent or caretaker.

**Based on R.I. Department of Children, Youth and Families determination of death due to child abuse or neglect by parent or caretaker*

DCYF Caseload:

On December 31, 1999 the total active caseload of the Rhode Island Department of Children, Youth and Families was 8,064 children. This number includes 1,901 children in adoptive homes, whose adoptive parents receive subsidies or other financial support. This does not count the children in pending child abuse and neglect investigations or children enrolled in DCYF community-based programs. This is an increase of 4% since December 1995 when the total active caseload was 7,760 children.[13,14]

Children in DCYF Care by Living Arrangement



n = 8,064

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 1999. Percentages may not add up to 100% due to rounding

◆ Out-of-home placements include foster homes (relative, non-relative and specialized), placement with a relative or guardian, group home, shelter care, residential treatment, and medical facilities. As of December 31, 1999, there were 3,056 Rhode Island children under age 21 in the care of DCYF in out-of-home placements. An additional 114 were classified as runaways.[15]

◆ Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting foster care placement or a group home/treatment placement or who have run away from their current placement. Between January and December 1999, there was an average of 60 night-to-night placements per month. This is a decrease from last year when there was an average of 76 night-to-night placements per month. In 1999, an average of 20 teen boys and 40 teen girls per month were in night-to-night placements.[16]

Implementing the Adoption and Safe Families Act

◆ The Adoption and Safe Families Act of 1997 prompted fundamental changes in the way the nation's foster care system is managed. Prior to the changes, some children remained in temporary, out-of-home care while prolonged attempts were made to reunite them with their biological family. Under the amended provisions states are required to find these children a safe, permanent home more quickly. The law shortens the time frame for a child's first permanency hearing, offers states financial incentives for increasing the number of adoptions, and sets new requirements for states to petition for termination of parental rights.[17,18]

◆ In 1999 in Rhode Island, 324 petitions for termination of parental rights (TPR) were filed in Rhode Island Family Court. During 1999, there were 385 TPRs granted (some of these were filed in previous years). In 1997, the Rhode Island General Assembly passed a law which would allow Family Court to establish a voluntary mediation program for termination of parental rights and child protection matters.[19]

◆ As of July, 1999 there were 140 Rhode Island children waiting to be adopted.[20]

Children Turning Age 18 While in Foster Care

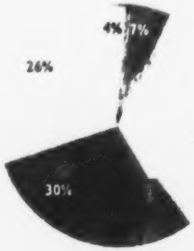
◆ Nationally, over 25,000 children age out of the foster care system, reaching the age of 18 without being adopted. In Rhode Island, teens represent one-quarter of the children in foster care. In 1999, Congress passed the "John H. Chafee Foster Care Independence Act" that provides federal funding for foster care teens after they turn 18. The resources are meant to help teens leaving the foster care system make a successful transition to self-sufficiency as adults.[21]

Children in Foster Care Homes, Rhode Island, 1999

◆ In Rhode Island as of December 1999, there were 1,318 children in foster care homes. Of these, 51% percent of the children were in non-relative foster homes, 41% were in relative foster homes, and 8% were in the care of private agencies. There were 529 licensed foster care homes, 404 certified foster care homes, and 111 licenses pending.[22]

By Age

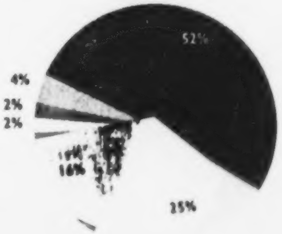
7%	■	Under Age 1
33%	□	Ages 1 to 5
30%	■	Ages 6 to 11
26%	□	Ages 12 to 17
4%	▨	Age 18+



n=1,318

By Race and Ethnicity

52%	■	White
25%	□	Black
16%	■	Hispanic
2%	□	Asian
2%	▨	American Indian
4%	□	Unknown



n=1,318

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), December 1999.

◆ Child abuse and neglect happens to children of all races, in all kinds of communities, in all economic classes. But national data indicate that poor families and families of color are more likely to be identified by the child welfare system and are more likely to have their children removed and placed in foster care. Once in foster care, children of color are more likely to remain there for long periods of time, and to experience multiple placements in different homes.[23]

Table 20

Indicated Cases of Child Abuse & Neglect, Rhode Island, 1999

CITY/TOWN	TOTAL POPULATION OF CHILDREN UNDER AGE 21	NUMBER OF INDICATED CASES OF CHILD ABUSE/NEGLECT	1999 RATE OF CASES OF CHILD ABUSE/NEGLECT PER 1,000 CHILDREN
Barrington	4,487	9	2.0
Bristol	6,186	44	7.1
Burrillville	5,109	27	5.3
Central Falls	5,579	106	19.0
Charlestown	1,783	21	11.8
Coventry	8,880	52	5.9
Cranston	17,558	138	7.9
Cumberland	7,523	34	4.5
East Greenwich	3,346	11	3.3
East Providence	12,520	75	6.0
Exeter	1,710	8	4.7
Foster	1,358	5	3.7
Glocester	2,944	10	3.4
Hopkinton	2,123	15	7.1
Jamestown	1,282	4	3.1
Johnston	6,309	40	6.3
Lincoln	4,543	36	7.9
Little Compton	867	3	3.5
Middletown	5,598	28	5.0
Narragansett	3,757	15	4.0
Newport	7,858	84	10.7
New Shoreham	184	3	16.3
North Kingstown	6,993	69	9.9
North Providence	6,846	72	10.5
North Smithfield	2,724	11	4.0
Pawtucket	19,655	255	13.0
Portsmouth	4,716	17	3.6
Providence	52,674	700	13.3
Richmond	1,766	7	4.0
Scituate	2,809	9	3.2
Smithfield	5,955	5	0.8
South Kingstown	9,612	35	3.6
Tiverton	3,752	22	5.9
Warren	2,851	32	11.2
Warwick	21,596	160	7.4
Westerly	5,771	65	11.3
West Greenwich	1,067	5	4.7
West Warwick	7,818	128	16.4
Woonsocket	12,511	263	21.0
Out of State/Unknown	*NA*	*45*	*NA*
Core Cities	*98,277*	*1,408*	*14.3*
Remainder of State	*182,343*	*1,215*	*6.7*
Rhode Island	*280,620*	*2,623*	*9.3*

Source of Data for Table/Methodology

Data are from the State of RI Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), number of reports (indicated cases) for the period January 1, 1999 to December 31, 1999.

An indicated case is an investigated report of child abuse and neglect for which credible evidence exists that child abuse and/or neglect occurred. An indicated case can involve more than one child.

The denominator is the number of children under the age of 21 according to the 1990 Census of Population.

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[12] Rhode Island Department of Health, Hospital Discharge Database, FY 1998-1999.

[13] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 1995, 1999.

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Education

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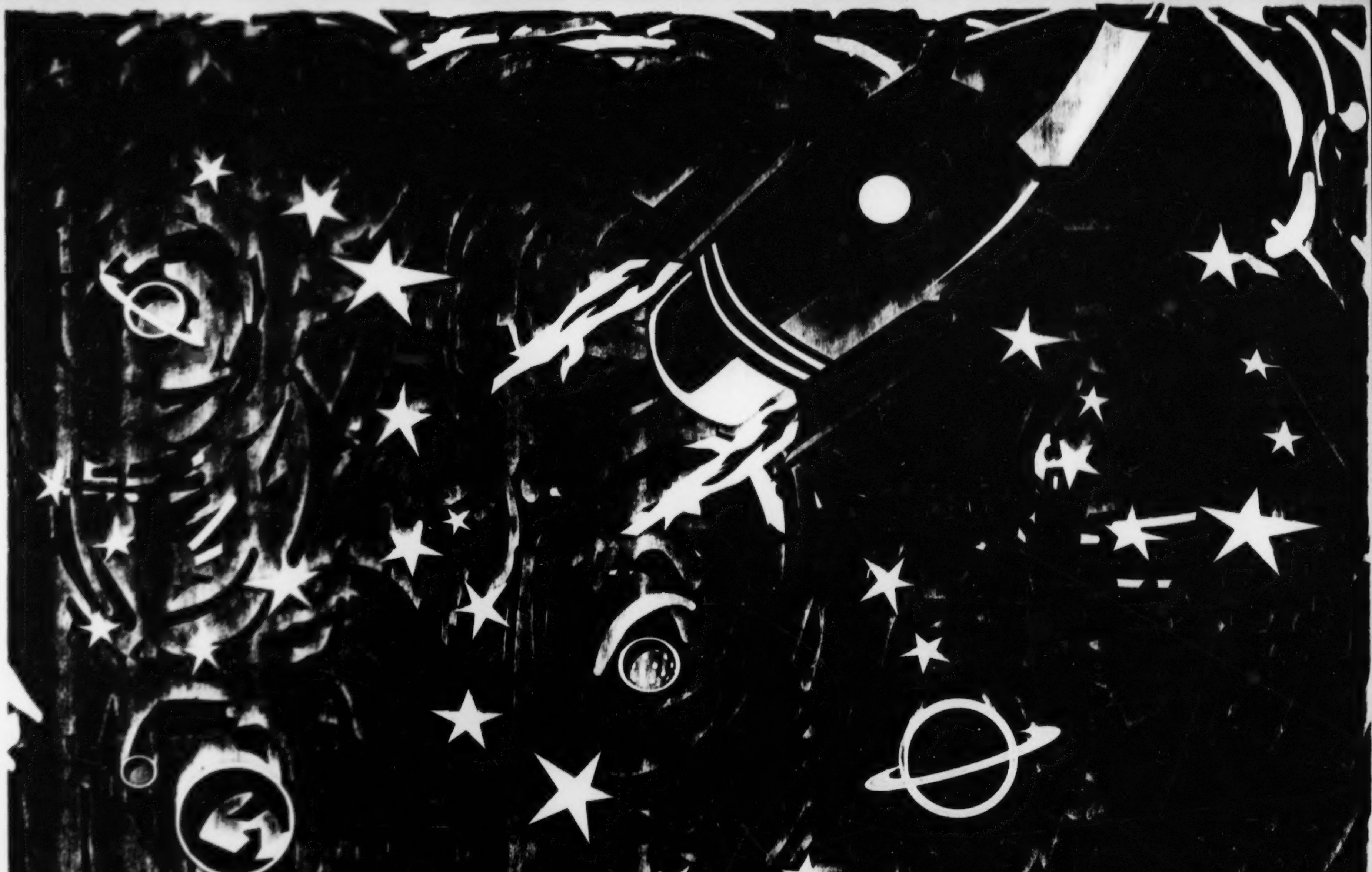
from High Flight

Oh, I have slipped the surly bonds of earth.
And danced the skies on laughter-silvered wings;
Sunward I've climbed and joined the tumbling mirth
Of sun-split clouds – and done a hundred things
You have not dreamed of – wheeled and soared and swung
High in the sunlit silence.

– John Gillespie Magee, Jr.



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Infant and Pre-School Child Care

DEFINITION

Infant and pre-school child care is the number of regulated child care slots per 100 children under age 6 in need of regulated child care. Regulated child care slots include full-time licensed child care center slots and certified family child care home slots.

SIGNIFICANCE

Child care has become a fundamental need for Rhode Island families over the past two decades. Well-designed child care programs can promote healthy cognitive, emotional and social development.[1] High quality child care provides a safe and nurturing learning environment for infants and young children. Recent brain research indicates that early care and education has long-lasting effects on how children learn and develop, cope with stress, and handle their emotions.

In quality child care programs children are cared for in environments that protect their health and safety and help them develop; children receive the attention they need in small groups with low-staff to child ratios; children learn from qualified teachers who are adequately compensated; and parents are involved in their child's early care experience.[2] Studies show that high quality child care programs are linked to school readiness. Children from all backgrounds who have received high quality child care score higher on tests of both cognitive and social skills in their early school years than children in poor quality care.[4] Low-income children who receive high quality early education score significantly higher on tests of reading and math from primary grades through middle adolescence.[5]

The quality and stability of child care is critical to a parent's ability to work.[6] In Rhode Island in 1997, 67% of mothers with children under the age of six were in the labor force.[7] More than 45,000 Rhode Island infants and pre-school children are in need of some form of child care because the mother is in the labor force.[8] Nationally, 50% of infants under age one, 68% of three-year-olds, and 78% of four-year-olds participate in some form of child care on a regular basis.[9,10] Changes in welfare laws linking cash assistance to work or participation in work-readiness programs will mean additional children in need of quality child care.

In 1999 in Rhode Island, there were an estimated 78 regulated child care slots for every 100 children under age six in need of a licensed child care center or certified family child care home.[11] This is an increase from 1998 when there were 70 slots per 100 children in need of care.

Quality Child Care is Linked to...

Professional Development

◆ A staff with more formal education and specialized early childhood training provides better quality services for children and families.[12]

◆ Professional training is most effective when providers learn about child and family development, management, and child care policies; gain credentials that are linked to compensation or transfer to other career pathways; and form networks of support, engage in continuous learning from their peers and become mentors to others.[13]

Wages and Benefits

◆ Annual turnover for child care providers is nearly three times the rate reported for U.S. companies as a whole and nearly five times the rate reported for public school teachers.[14]

◆ Experienced child care providers frequently leave their jobs because of low salaries and inadequate benefits. Child care providers are among the lowest paid workers in the labor market.[15]

Licensing

◆ The safety and healthy development of children require quality standards for the licensing and regulation of child care providers, including family child care homes.[16] Licensing standards focus on maintaining children's health and safety, setting staff-child ratios and group sizes that support child development, and setting minimum staff training requirements.

Accreditation

◆ The National Association for the Education of Young Children accreditation standards are based on research showing that children benefit emotionally, socially, and cognitively when centers demonstrate: developmentally-appropriate curriculum; low staff-to-child ratios; small group sizes; higher levels of staff education and training; low staff turnover; and higher levels of staff compensation.[17]

◆ In 1999 in Rhode Island, 25 of the 250 licensed child care centers are accredited by the National Association for the Education of Young Children and 10 of the 883 certified family child care homes are accredited by the National Association for Family Child Care.[18]

Infant and Pre-School Child Care

Table 21

Child Care for Children Under Age 6, Rhode Island, 1999

CITY/TOWN	# CHILD CARE CENTER SLOTS < AGE 3	# CHILD CARE CENTER SLOTS AGES 3-5	# CERTIFIED FAMILY CHILD CARE HOME SLOTS*	TOTAL REGULATED CHILD CARE SLOTS FOR CHILDREN < AGE 6	POTENTIAL CHILDREN < AGE 6 IN NEED OF REGULATED CHILD CARE	SLOTS PER 100 CHILDREN < 6 IN NEED OF REGULATED CHILD CARE
Barrington	96	241	52	389	314	124
Bristol	53	104	85	242	591	41
Burrillville	0	69	52	121	476	25
Central Falls	0	90	95	185	718	26
Charlestown	16	12	16	44	167	26
Coventry	55	171	226	452	773	58
Cranston	301	845	398	1,544	1,506	102
Cumberland	60	73	198	331	655	51
East Greenwich	191	347	26	564	182	309
East Providence	224	590	174	988	1,276	77
Exeter	0	35	14	49	165	30
Foster	30	36	5	71	109	65
Glocester	16	66	40	122	267	46
Hopkinton	0	0	34	34	186	18
Jamestown	31	33	25	89	97	92
Johnston	105	353	123	581	521	112
Lincoln	176	345	78	599	414	145
Little Compton	0	0	0	0	87	0
Middletown	140	330	30	500	471	106
Narragansett	41	90	46	177	328	54
Newport	126	210	58	394	641	61
New Shoreham	0	0	0	0	24	0
North Kingstown	128	336	91	555	596	93
North Providence	67	175	148	390	613	64
North Smithfield	0	0	66	66	186	35
Pawtucket	214	616	401	1,231	2,455	50
Portsmouth	63	98	38	199	390	51
Providence	847	2,297	1,835	4,979	5,557	90
Richmond	0	37	49	86	173	50
Scituate	47	92	18	157	260	60
Smithfield	160	356	56	572	366	156
South Kingstown	130	277	89	496	479	104
Tiverton	25	145	56	226	294	77
Warren	25	152	35	212	332	64
Warwick	420	1,079	322	1,821	1,725	106
Westerly	72	355	12	439	570	77
West Greenwich	57	87	6	150	92	162
West Warwick	143	375	105	623	705	88
Woonsocket	105	407	193	705	1,383	51
Core Cities	*1,292*	*3,620*	*2,582*	*7,494*	*10,754*	*70*
Remainder of State	*2,872*	*7,304*	*2,713*	*12,889*	*15,389*	*84*
Rhode Island	*4,164*	*10,924*	*5,295*	*20,383*	*26,143*	*78*

**Family child care home slots are for children birth to 12-years-old.*

Source of Data for Table/Methodology

The denominator is the potential number of children in need of regulated care, see methodology on page 96. The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots as of December 1999. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

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[5] *Early Learning, Later Success: The Abecedarian Study, Executive Summary* (1999). Chapel Hill, NC: Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

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[7] U.S. Bureau of the Census, Current Population Survey, 1995 to 1999 average.

[8] U.S. Bureau of the Census, 1990 Census of Population.

[9] Booth, C. (1999). *Consequences of Early Child Care: Studying the Contexts of Early Experiences in the 1990's.* Washington, DC: NICHD Early Child Care Research Network.

[11] Calculations by Rhode Island KIDS COUNT based on data from the Rhode Island Department of Human Services (December 1999), the U.S. Bureau of the Census (1990), and Options for Working Parents (December 1999).

[10] Lopez, E.M. (1997). *Quality in Family and Child Care Partnerships.* Cambridge, MA: Harvard Family Research Project.

[9] Options for Working Parents, December 1999.

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Children Enrolled in Head Start

DEFINITION

Children enrolled in Head Start is the percentage of eligible 3 and 4 year old children enrolled in the Head Start preschool program as of October 1, 1999.

SIGNIFICANCE

Head Start is a comprehensive early childhood program for low-income preschool children and their families. The program seeks to promote the healthy development of children in low-income families and help their parents achieve economic security. Most children in the program attend for one year and are four years old.[1] Children are eligible for Head Start if their family's income is below 100% of the federal poverty line; the family receives SSI or is enrolled in the Family Independence Program; or the family is using supportive services that are federal TANF benefits, such as transportation vouchers, subsidized child care, or job training. Up to 10% of the children served by Head Start can be in families that do not meet these eligibility guidelines, especially if the child has a special need.

Head Start performance standards require that programs deliver a high-quality early childhood education program; involve parents in program policy and planning; provide at least one nutritional meal per day; identify children's individual nutritional needs; ensure that each child has an ongoing source of health care; perform or obtain health, developmental and behavioral screenings; and make arrangements for mental health professionals to be available to identify mental health concerns and help locate needed treatment.[2]

The Head Start program is designed to provide low-income children with the socialization and school-readiness skills they need to enter public schools on an equal footing with more economically advantaged children.[3]

Participants in quality early childhood programs demonstrate a stronger commitment to school, have better relationships with their peers, and exhibit better classroom behavior.[4] They are less likely to be held back in school or to be placed in special education classes.[5] They are more likely to be successful in school and to graduate, to have higher earnings and less welfare dependency, and to report fewer arrests and out-of-wedlock births.[6]

Early Head Start

◆ In response to research indicating that the period from birth to age three is critical to healthy growth and development and later school success, Head Start now offers a program for pregnant women and their infants and children up to age three. In Rhode Island, 291 families receive services through Early Head Start.

◆ The goals of the federally-funded Early Head Start program are to enhance children's physical, social, emotional, and cognitive development; enable parents to be better caregivers of and teachers to their children; and help parents meet their own goals, including that of economic independence.[7]

Low-Income Children Benefit from Comprehensive Programs

◆ Studies show that children in poor families are at greater risk for developmental delays, learning disabilities, and behavior problems; have a greater prevalence of health and nutrition problems; and are more likely to live in substandard housing and be exposed to violence and substance abuse.[8]

◆ Disadvantaged children are most sensitive to the effects of poor quality child care and benefit most from high quality comprehensive child care programs.[9] Comprehensive programs that focus both on child development and family development are most effective in supporting vulnerable families and children.[10]

◆ A recent study — The Abecedarian Project, conducted by the University of North Carolina — tracked a group of low-income children from infancy to age 21. The research shows that children who received a high quality early education program combined with health, social and nutritional services consistently outperformed their peers on both cognitive and academic tests and were more than twice as likely to attend college and hold high-skilled jobs.[11]

◆ Under Starting RIght, Rhode Island's child care law, resources have been appropriated to expand Head Start and to create comprehensive child care programs in underserved communities. Comprehensive child care programs will provide a developmentally-appropriate education program and link with other community programs to provide health, nutrition, mental health, and social services; services for children with special needs; and assistance with transition to kindergarten.

Children Enrolled in Head Start

Table 22 **Percent of Eligible Children Ages 3 and 4 Enrolled in Head Start, Rhode Island, 1999**

CITY/TOWN	ESTIMATED ELIGIBLE CHILDREN AGED 3&4	NUMBER OF CHILDREN ENROLLED IN HEAD START	% OF ELIGIBLE 3&4 YEAR OLDS ENROLLED
Barrington	5	5	100%
Bristol	35	30	86%
Burrillville	26	25	96%
Central Falls	283	55	19%
Charlestown	12	3	25%
Coventry	63	39	62%
Cranston	206	211	100%
Cumberland	40	15	38%
East Greenwich	13	4	31%
East Providence	160	85	53%
Exeter	7	2	29%
Foster	3	0	0%
Glocester	9	11	100%
Hopkinton	18	10	56%
Jamestown	3	0	0%
Johnston	72	44	61%
Lincoln	30	13	43%
Little Compton	1	4	100%
Middletown	26	38	100%
Narragansett	27	12	44%
Newport	194	139	72%
New Shoreham	2	0	0%
North Kingstown	56	37	66%
North Providence	92	43	47%
North Smithfield	6	2	33%
Pawtucket	589	114	19%
Portsmouth	11	10	91%
Providence	2,386	908	38%
Richmond	9	4	44%
Scituate	11	1	9%
Smithfield	11	5	45%
South Kingstown	28	17	61%
Tiverton	17	29	100%
Warren	32	27	84%
Warwick	203	139	68%
Westerly	62	51	82%
West Greenwich	3	2	67%
West Warwick	145	137	94%
Woonsocket	395	220	56%
Core Cities	*3,846*	*1,436*	*37%*
Remainder of State	*1,447*	*1,055*	*73%*
Rhode Island	*5,293*	*2,491*	*47%*

Source of Data for Table/Methodology

Rhode Island Head Start Programs, children enrolled on October 1, 1999, U.S. Department of Health and Human Services, Region 1, Administration on Children, Youth and Families; and Rhode Island Department of Human Services INRHODES Database, December 1, 1996-1998.

The denominator is the estimated number of eligible children based on a three-year average of the number of three- and four-year-old children in families receiving FIP at a single point in time during each of three years: 1996, 1997, and 1998. This is an underestimate of children eligible, because it does not include children eligible for Head Start who live in non-AFDC/non-FIP families living below the poverty line. Therefore, the actual percentage of eligible served is likely to be lower than shown here.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

[1] *The Future of Children: Long-Term Outcomes of Early Childhood Programs* (1995). "Head Start". (Vol.5, No. 3). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[2] Schulman, K., Blank, H., and Ewen, D. (1999). *Seeds to Success: State Prekindergarten Initiatives, 1998-1999.* Washington, DC: Children's Defense Fund.

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[11] *Early Learning, Later Success: The Abecedarian Study, Executive Summary* (1999). Chapel Hill: NC: Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

School-Age Child Care

DEFINITION

School-age child care is the number of licensed child care programs and slots for children ages 5 to 12. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 5 to 12 that do not require licensing by the state.

SIGNIFICANCE

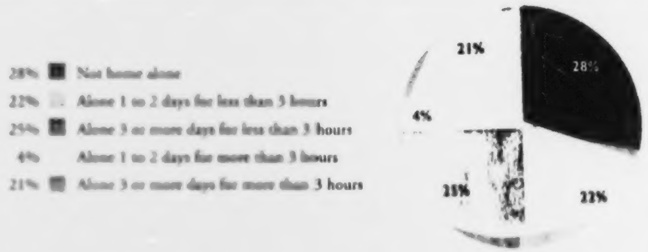
Many parents need care for their school-age children during work hours. Children spend fewer than one-third of their waking hours in school. The gap between parents' work schedules and students' school schedules can amount to 20 to 25 hours per week.[1] Schools are typically open less than half the days of the year and in many cases are open only until mid-afternoon. Many children are alone during the hours before and after school. Older children are much more likely than younger children to spend time on their own.[2]

Low-income children and children in urban or high-crime neighborhoods are most at risk when they spend time caring for themselves.[3] Children who are without adult supervision when school is out are at significantly greater risk of truancy from school, emotional stress, receiving poor grades, substance use, sexual activity, and crime.[4] Juvenile crime peaks between the hours of 3 p.m. and 8 p.m., and triples between 2 p.m. and 3 p.m.[5] Children ages 6 to 17 are also more likely to be the victims of violent crime between 2 p.m. and 6 p.m.[6]

When school is out, children and young adolescents need a safe place that does not simply duplicate the school day. They need access to a wide variety of enriching activities — homework and reading help, sports, music, theater, art — and the opportunity to build meaningful relationships with their peers and caring adults.[7] Children in high quality, well-designed after-school programs have better peer relations, emotional adjustment, grades, and conduct in school than their peers in other care arrangements.[8] Yet, many programs are of poor quality due to a lack of resources, staff turnover, and inappropriate space.[9]

In Rhode Island, the supply of licensed child care for children ages 5 to 12 significantly increased from 8,652 slots in 1998 to 12,267 slots in 1999. The number of school-age child care slots in 1999 was more than double the number in 1995 (5,570).[10] Yet there continues to be a relatively low supply of before and after-school care relative to need. Parents find it particularly difficult to locate suitable after-school programs for middle school-age children.[11,12] In Rhode Island, as of December 1, 1999, there were 1,349 licensed slots for youth ages 11 to 15.[13]

Rhode Island Middle School Children, At Home After School without Adult Supervision, 1999



◆ One in five (21%) Rhode Island middle school children (grades 6, 7 and 8) are home after school without adult supervision for more than three hours on at least three days a week. An additional 4% are home without adult supervision for more than three hours on one or two days a week.

◆ Rhode Island middle school students from low-income families are less likely than students from high-income families to participate in extracurricular activities and programs. In 1999, 67% of low-income middle school children belonged to and regularly attended at least one extracurricular activity compared to 82% of higher-income families.

Source: Robert D. Felner, PhD (1999). *Information Works! SALT Survey Reports: Measuring Rhode Island Schools for Change 1998-1999.* Providence, RI: University of Rhode Island, National Center on Public Education and Social Policy.

Subsidies for School-Age Care in Rhode Island

◆ Under Starting Right, Rhode Island's child care law, child care subsidies are an entitlement for all families with incomes less than 225% of poverty ($37,575 for a family of four). The subsidies can be used for after-school programs for children up to age 16. As of December 1999, there were 3,869 children ages 6 to 16 that were using subsidies for school-age child care programs, one-third of all child care subsidies.[14]

Table 23.

Licensed School-Age Child Care for Children Ages 5 to 12, Rhode Island, 1999

	COMMUNITY-BASED		SCHOOL-BASED		TOTAL	
CITY/TOWN	**PROGRAMS**	**SLOTS**	**PROGRAMS**	**SLOTS**	**PROGRAMS**	**SLOTS**
Barrington	5	206	1	30	6	236
Bristol	3	52	2	90	5	142
Burrillville	1	38	2	135	3	173
Central Falls	1	49	2	112	3	161
Charlestown	1	18	0	0	1	18
Coventry	2	51	6	287	8	338
Cranston	7	233	8	269	15	502
Cumberland	1	25	3	150	4	175
East Greenwich	1	40	2	152	3	192
East Providence	3	130	10	527	13	657
Exeter	1	26	2	70	3	96
Foster	2	61	0	0	2	61
Glocester	0	0	1	75	1	75
Hopkinton	0	0	1	40	1	40
Jamestown	0	0	1	50	1	50
Johnston	2	44	2	99	4	143
Lincoln	2	45	2	85	4	130
Little Compton	1	26	0	0	1	26
Middletown	3	58	4	171	7	229
Narragansett	0	0	1	25	1	25
Newport	2	121	6	223	8	344
New Shoreham	0	0	0	0	0	0
North Kingstown	5	84	2	90	7	174
North Providence	1	100	0	0	1	100
North Smithfield	0	0	1	78	1	78
Pawtucket	6	560	3	170	9	730
Portsmouth	1	32	1	35	2	67
Providence	24	1,305	31	3,034	55	4,339
Richmond	0	0	1	30	1	30
Scituate	2	37	2	125	4	162
Smithfield	1	8	3	240	4	248
South Kingstown	1	18	6	270	7	288
Tiverton	1	20	0	0	1	20
Warren	1	85	2	100	3	185
Warwick	12	578	8	347	20	925
Westerly	4	133	4	180	8	313
West Greenwich	1	36	0	0	1	36
West Warwick	3	179	6	277	9	456
Woonsocket	3	189	2	114	5	303
Core Cities	*36*	*2,224*	*44*	*3,653*	*80*	*5,877*
Remainder of State	*68*	*2,363*	*84*	*4,027*	*152*	*6,390*
Rhode Island	*104*	*4,587*	*128*	*7,680*	*232*	*12,267*

Source of Data for Table/Methodology

All data are from Options for Working Parents, Greater Providence Chamber of Commerce, December 1999.

Number of licensed school-age child care programs and slots for children ages 5 to 12 as of December 1999. School-based programs are school-age child care programs located in schools and may be administered through the school district or a community organization (for example, YWCA, YMCA, etc.). Community-based programs are school-age child care programs located in the community, including child care centers, YMCAs, YWCAs, Boys and Girls Clubs, and other community organizations. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 5 to 12 that do not require licensing by the state.

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Children Receiving Child Care Subsidies

DEFINITION

Children receiving child care subsidies is the number of children receiving child care that is either fully or partially paid for with a child care subsidy from the Rhode Island Department of Human Services. Child care subsidies are available to families with income at or below 225% of the federal poverty level ($37,575 for a family of four). Child care subsidies can be used for care by a child care center, family child care home, a relative, or an in-home caregiver.

SIGNIFICANCE

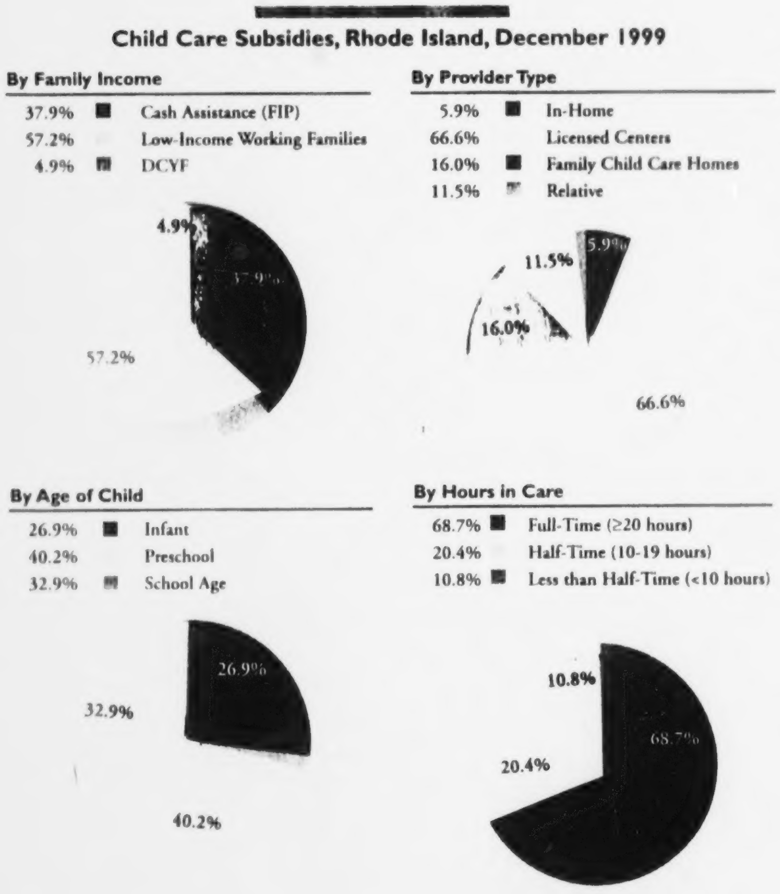
The cost of full-time child care often represents the largest expense, after housing, for working parents who need full time care for their children. Without a child care subsidy, a low-income family can spend as much as 33% of their income on child care expenses. The less families earn, the higher the proportion of income spent on child care.[3]

For many low-income and moderate-income families, the cost of child care can limit access to high quality programs. The quality and stability of child care is critical to a parent's ability to work and to healthy child development.[1,3] National studies show that among mothers of all income levels, higher-cost child care is associated with a higher probability of refusing or terminating employment.[4,5]

Rhode Island is the only state that has a legal entitlement to a child care subsidy for income-eligible families. Working families with incomes up to 225% of the federal poverty line are entitled to a child care subsidy for their children up to age 15. Families receiving subsidies may have a co-payment based on family income. Families participating in the Rhode Island Family Independence Program who are working or enrolled in education, training or work-related activities are eligible for child care at no cost to the family.

Four out of five (83%) Rhode Island families receiving child care subsidies choose licensed child care centers or certified family child care homes for their child care arrangements.[6] Even as more child care subsidies become available, there is a structural shortage of child care centers and certified family child care homes necessary to meet demand.[7] The supply of licensed and certified child care is especially limited in low-income communities and rural areas, for infants and children under age 3, for children with disabilities and special health care needs, for middle school-age children, and for parents with unconventional or shifting work hours.[8]

Child Care Subsidies, Rhode Island, December 1999



By Family Income

37.9%	■	Cash Assistance (FIP)
57.2%	□	Low-Income Working Families
4.9%	▨	DCYF

By Provider Type

5.9%	■	In-Home
66.6%	□	Licensed Centers
16.0%	■	Family Child Care Homes
11.5%	▨	Relative

By Age of Child

26.9%	■	Infant
40.2%	□	Preschool
32.9%	▨	School Age

By Hours in Care

68.7%	■	Full-Time (≥20 hours)
20.4%	□	Half-Time (10-19 hours)
10.8%	■	Less than Half-Time (<10 hours)

Total Number of Subsidies is 10,703 as of December 1999.

Source: Rhode Island Department of Human Services, December 1999.

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Children Receiving Child Care Subsidies

Table 24.

Child Care Subsidies, Rhode Island, 1999

	COMMUNITY CONTEXT		NUMBER OF CHILD CARE SUBSIDIES			
CITY/TOWN	# OF CHILDREN UNDER AGE 16 IN WORKING FAMILIES < 185% POVERTY	# OF CHILDREN UNDER AGE 16 ENROLLED IN FIP*	BIRTH TO AGE 3	AGES 3-5	AGES 6-16	TOTAL CHILD CARE SUBSIDIES
Barrington	49	27	23	24	10	57
Bristol	809	222	22	43	21	86
Burrillville	518	131	2	32	39	73
Central Falls	2,935	1,683	68	47	60	175
Charlestown	152	71	7	10	1	18
Coventry	748	276	35	43	25	103
Cranston	1,734	1,228	183	289	172	644
Cumberland	540	183	39	28	16	83
East Greenwich	81	87	49	45	12	106
East Providence	2,352	837	167	187	106	460
Exeter	149	23	1	1	0	2
Foster	109	27	4	7	7	18
Glocester	265	50	9	10	2	21
Hopkinton	154	60	0	0	0	0
Jamestown	55	18	1	3	3	7
Johnston	587	460	61	84	47	192
Lincoln	270	159	118	94	29	241
Little Compton	47	11	1	0	0	1
Middletown	542	94	55	78	26	159
Narragansett	333	144	17	24	5	46
Newport	1,489	923	106	104	94	304
New Shoreham	13	3	0	0	0	0
North Kingstown	590	269	38	70	51	159
North Providence	729	485	37	57	13	107
North Smithfield	141	46	12	23	22	57
Pawtucket	6,851	3,430	350	562	529	1,441
Portsmouth	190	61	8	7	10	25
Providence	16,851	14,885	1,210	1,708	1,753	4,671
Richmond	142	60	3	1	2	6
Scituate	166	36	10	8	10	28
Smithfield	170	55	41	48	15	104
South Kingstown	377	190	5	11	61	77
Tiverton	290	90	9	18	7	34
Warren	488	179	22	39	52	113
Warwick	2,244	1,060	235	408	340	983
Westerly	657	339	42	56	37	135
West Greenwich	109	28	1	0	1	2
West Warwick	1,363	700	109	165	59	333
Woonsocket	3,572	2,502	129	216	135	480
Out of State	*0*	*0*	*88*	*179*	*97*	*364*
Core Cities	*32,435*	*23,423*	*1,863*	*2,637*	*2,571*	*7,071*
Remainder of State	*16,476*	*7,709*	*1,454*	*2,092*	*1,298*	*4,844*
Rhode Island	*50,216*	*31,132*	*3,317*	*4,729*	*3,869*	*11,915*

**FIP is the Family Independence Program*

Notes to Table

See page 97 for methodology used to estimate the number of children under age 16 in working families less than 185% of poverty. Some of these children will not require a child care subsidy because they are in unpaid care by parents or relatives.

The total number of subsidies in Table 24 is a total of the following: the 10,703 children receiving subsidies as of December 1999; the 352 children for whom retroactive subsidy payments were made in December 1999; and the 860 children in FIP families that claimed a "child care disregard" in lieu of a child care subsidy.

Parents who are working and are enrolled in the Family Independence Program can claim a "child care disregard." When DHS calculates cash benefits levels based on monthly income, the child care disregard allows families to not count or "disregard" up to $200 of their monthly income which they can designate for child care expenses.

Source of Data for Table/Methodology

The Rhode Island Department of Human Services, INRHODES Database, December 1, 1999.

Providence Chamber of Commerce, Options for Working Parents, December 1, 1999.

References for Indicator

[1] Phillips, D. & Bridgman, A. (1995). *New Findings on Children, Families, and Economic Self-Sufficiency.* Washington, DC: Institute of Medicine.

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[7,8] *Rhode Island KIDS COUNT Special Report: Building an Early Care and Education System in Rhode Island* (December 1999). Providence, RI: Rhode Island KIDS COUNT.

Full-Day Kindergarten

DEFINITION

Full-day kindergarten is the percentage of public school kindergarten children enrolled in a full-day kindergarten program. Full-day kindergarten is defined here as a kindergarten program that operates for at least six hours per day. The numbers do not include children enrolled in private kindergarten programs or in half-day kindergarten programs that offer after-school child care.

SIGNIFICANCE

Research shows that many children benefit academically and socially from participation in full-day kindergarten as compared to half-day kindergarten programs.[1] Full-day kindergarten programs are especially beneficial to children from low-income and educationally disadvantaged backgrounds.[2]

The increase in single parent families, the increase in the number of families with both parents working, and the fact that most children have experience with full-day preschool or child care programs has increased the demand for full-day kindergarten. Studies show that parents favor a full-day program that reduces the number of transitions that their kindergarten child must make each day.[3]

Teachers and parents report that children in full-day kindergarten have more time to discover at a relaxed pace, more opportunities to choose activities and develop their own interests, and more time for creative activities.[4] The longer school day allows children and teachers time to explore topics in depth; reduces the ratio of transition time to class time; provides for greater continuity of daily activities; and provides an environment that supports a child-centered, developmentally-appropriate approach. Full-day kindergartners exhibit more independent learning, classroom involvement, productivity in work with peers, and reflectiveness than half-day kindergartners.[5]

Teachers in full-day programs are better able to assess children's progress.[6] In a full-day program, teachers and school staff have more opportunities to recognize a child's learning style and identify problems or behavioral issues. This allows for more timely intervention, and the potential to reduce costs associated with remedial and special education in later school years.[7]

Children in Full-Day Public Kindergarten Programs

- **Eight of Rhode Island's thirty-six school districts offer full-day kindergarten. Of these, three school districts — Middletown, New Shoreham and Newport — offer universal access to full-day kindergarten programs. Five districts — Providence, North Smithfield, Central Falls, Westerly, and Warwick — select children for the full-day kindergarten program by lottery or based on special needs or risk categories.**

- **Fewer than one in five (18%) Rhode Island children attend a public full-day kindergarten program compared to about half of all children nationally.[8]**

- **In the core cities, 43% of children attend full-day kindergarten programs, including 68% of children in Providence, 92% of children in Newport, and 18% of children in Central Falls. Pawtucket and Woonsocket do not offer full-day kindergarten programs.**

Source: Rhode Island Department of Elementary and Secondary Education, 1999-2000 school year.

Readiness for First Grade

- **Research indicates that children who attend full-day kindergarten score higher on first grade reading readiness tests and on reading and achievement tests in the elementary grades.[9]**

- **Full-day kindergarten helps to level academic disparities among students entering the first grade. In a full-day program, teachers have more opportunities to assess and address the needs of children who come from disadvantaged backgrounds, speak English as a second language, have developmental delays, or have had limited experience with a formal educational setting.[10]**

- **A 1999 study by the Providence Demography Initiative found that children who attended half-day kindergarten programs were nearly twice as likely to repeat the first grade as children who attended a full-day program.[11]**

Table 25 **Children Enrolled in Full-Day Kindergarten Programs, Rhode Island, 1999-2000**

SCHOOL DISTRICT	TOTAL NUMBER OF CHILDREN ENROLLED IN PUBLIC KINDERGARTEN PROGRAMS	NUMBER OF CHILDREN ENROLLED IN FULL-DAY KINDERGARTEN	% OF CHILDREN ENROLLED IN FULL-DAY KINDERGARTEN
Barrington	214	0	0%
Bristol-Warren	255	0	0%
Burrillville	164	0	0%
Central Falls	250	44	18%
Chariho	292	0	0%
Coventry	381	0	0%
Cranston	737	0	0%
Cumberland	373	0	0%
East Greenwich	165	0	0%
East Providence	443	0	0%
Exeter-W. Greenwich	129	0	0%
Foster	55	0	0%
Foster-Glocester	0	0	0%
Glocester	124	0	0%
Jamestown	59	0	0%
Johnston	241	0	0%
Lincoln	232	0	0%
Little Compton	38	0	0%
Middletown	258	211	82%
Narragansett	125	0	0%
Newport	225	206	92%
New Shoreham	8	8	100%
North Kingstown	313	0	0%
North Providence	211	0	0%
North Smithfield	122	55	45%
Pawtucket	788	0	0%
Portsmouth	214	0	0%
Providence	2,117	1,431	68%
Scituate	107	0	0%
Smithfield	177	0	0%
South Kingstown	278	0	0%
Tiverton	144	0	0%
Warwick	766	29	4%
Westerly	282	10	4%
West Warwick	260	0	0%
Woonsocket	522	0	0%
Core Cities	*3,902*	*1,681*	*43%*
Remainder of State	*7,167*	*313*	*4%*
Rhode Island	*11,069*	*1,994*	*18%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 1999. Data are as of October 1999 and are for the 1999-2000 school year. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

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[7] National Association of School Psychologists (1997). *Full-day Versus Half-day Kindergarten Programs: A Brief History and Synopsis.*

[11] *Information Works! A Statewide Analysis 1999* (1999). Providence: Rhode Island Department of Education (citing the 1999 Providence Demography Initiative, *Counting on Ourselves*).

Children Enrolled in Special Education

DEFINITION

Children enrolled in special education is the number of children ages 3 to 22 who are enrolled in special education in Rhode Island elementary and secondary schools.

SIGNIFICANCE

Most children with disabilities have a limitation caused by one or more chronic physical conditions, cognitive conditions, or significant impairments in social, emotional or behavioral functioning in comparison with their peers of the same age.[1] Whether disabilities are mild or severe, they have the potential to create special needs related to physical health, mental health, education, parent support, child care, recreation, and career preparation.[2]

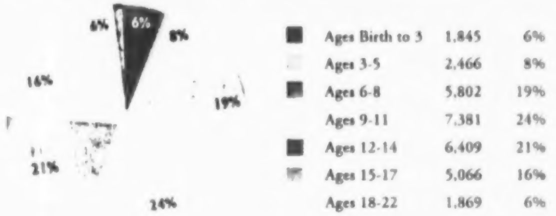
Children with disabilities are a heterogeneous group, varying by type of disability and age of the child, as well as by the many differences in the population at large - such as family income, race, ethnicity, primary language, and parents' educational level.[3] While there are wide variations in the specific needs of each child, there are some issues of common concern to families of children with disabilities.[4] Children with disabilities need access to health care that is appropriate to their special needs.[5] Children who meet certain disability criteria are eligible for Medicaid and/or cash assistance through the Supplemental Security Income (SSI) program.[6] Some children with disabilities may require costly therapeutic and health care services, wheelchairs, or home modifications. Because many services are not fully covered by insurance, families from all income levels can incur serious financial burdens.

States are required to provide appropriate early intervention services to all children from birth to age 3 who are developmentally delayed or have been diagnosed with a physical or mental condition that has a high probability of resulting in developmental delay.[7] The local school system is responsible for identifying and evaluating students ages 3 to 22 whom it is has reason to believe are students with disabilities and therefore might require special education and related services.[8]

In 1999, the five Early Intervention programs in Rhode Island served 1,845 children ages birth to three who were developmentally delayed or at risk.[9]

In the 1998-1999 school year, there were 28,993 Rhode Island children (14% of the student population) who received special education services. Of these, 70% were classified as learning disabled; 24% speech disorders; 10% behavioral disorders; 8% health-impaired; 7% developmentally delayed; 6% mentally retarded; and 4% other disabilities.[10]

Children Enrolled in Early Intervention* and Special Education, By Age, Rhode Island, School Year 1998-1999



n = 30,838

Source: Special Education data are from the Rhode Island Department of Elementary and Secondary Education, Office of Special Education, June 30, 1999. *Early intervention data for children birth to 3 are from the Rhode Island Department of Health, Division of Family Health, Early Intervention Database, June 30, 1999.

Inclusion of Students with Disabilities

◆ The services described in the Individualized Education Plan must be provided in the least restrictive environment, i.e. to the extent appropriate to the child's needs, the child should receive special services in a setting that is integrated with other children, with and without disabilities. This is sometimes referred to as "inclusion" or "mainstreaming." However, the IDEA does not mandate inclusion unless it is appropriate to the needs of the child.[11]

◆ Inclusion is meant to raise expectations for student performance, provide opportunities for children with disabilities to learn alongside their nondisabled peers, improve coordination between regular and special educators, and increase school-level accountability for performance.[12]

◆ Between 1986 and 1996 in the U.S., the percentage of students with disabilities who were educated in regular classrooms increased by 20%, while the percentage served in resource rooms, separate classes, and separate residential facilities decreased.[13]

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Children Enrolled in Special Education

Table 26.

Children and Youth in Special Education, by Primary Disability, Ages 3-22, Rhode Island, 1998-1999

SCHOOL DISTRICT	TOTAL # OF STUDENTS	BEHAVIORALLY DISORDERED	MENTALLY RETARDED	ORTHO-PEDICALLY IMPAIRED	HEALTH IMPAIRED	LEARNING DISABLED	SPEECH DISORDER	DEVELOP-MENTALLY DELAYED	OTHER	TOTAL STUDENTS WITH DISABILITIES	% STUDENTS IN SPECIAL EDUCATION
Barrington	3,099	29	8	0	10	316	126	15	26	530	17%
Bristol Warren	3,911	45	55	7	16	476	164	31	18	812	21%
Burrillville	2,960	75	27	0	61	271	129	13	11	587	20%
Central Falls	3,268	99	51	5	28	478	83	45	25	814	25%
Chariho	3,885	43	15	6	60	317	153	26	32	652	17%
Coventry	5,475	69	49	7	37	679	126	53	15	1,035	19%
Cranston	10,784	97	28	6	112	1,508	347	61	49	2,208	20%
Cumberland	4,898	115	36	6	204	297	290	53	43	1,044	21%
East Greenwich	2,242	33	5	6	53	156	99	20	23	395	18%
East Providence	6,620	101	69	2	200	412	326	34	39	1,183	18%
Exeter-W. Greenwich	2,058	43	8	6	96	99	133	11	10	406	20%
Foster	399	1	0	0	2	8	29	4	1	45	11%
Foster Glocester	1,564	15	8	2	17	163	36	0	5	246	16%
Glocester	853	5	5	0	10	62	69	16	8	175	21%
Jamestown	662	4	5	3	19	62	24	3	8	128	19%
Johnston	3,492	32	21	2	50	477	174	31	13	800	23%
Lincoln	3,653	41	25	1	101	251	110	46	35	610	17%
Little Compton	354	4	2	0	4	47	19	2	1	79	22%
Middletown	2,809	42	11	1	50	286	137	7	14	548	20%
Narragansett	1,882	36	4	2	41	206	110	15	11	425	23%
Newport	3,020	63	12	15	11	459	86	46	11	703	23%
New Shoreham	144	4	0	0	0	12	13	1	0	30	21%
North Kingstown	4,536	47	6	9	16	427	200	20	14	739	16%
North Providence	3,511	52	24	5	73	293	176	29	21	673	19%
North Smithfield	1,787	23	5	1	46	142	76	11	14	318	18%
Pawtucket	9,951	196	146	8	73	840	406	152	57	1,878	19%
Portsmouth	2,763	21	8	3	43	207	190	6	17	495	18%
Providence	26,147	214	274	16	11	2,488	374	254	54	3,685	14%
Scituate	1,728	8	3	2	33	118	117	9	10	300	17%
Smithfield	2,727	11	7	5	38	202	136	19	13	431	16%
South Kingstown	4,270	75	25	3	34	404	225	19	28	813	19%
Tiverton	2,190	19	5	1	21	197	124	4	12	383	17%
Warwick	12,138	217	83	14	184	1,329	312	225	83	2,447	20%
Westerly	3,598	44	8	6	63	366	199	19	31	736	20%
West Warwick	3,696	79	13	7	14	438	184	29	13	777	21%
Woonsocket	6,636	167	137	7	211	651	254	71	54	1,552	23%
**State Run Schools*	*1,075*	*15*	*8*	*3*	*5*	*142*	*9*	*0*	*129*	*311*	*29%*
Core Cities	*49,022*	*739*	*620*	*51*	*334*	*4,916*	*1,203*	*568*	*201*	*8,632*	*18%*
Remainder of State	*154,785*	*2,184*	*1,196*	*167*	*2,047*	*15,286*	*5,765*	*1,400*	*948*	*20,361*	*13%*
Rhode Island	*203,807*	*2,923*	*1,816*	*218*	*2,381*	*20,202*	*6,968*	*1,968*	*1,149*	*28,993*	*14%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 1998-1999 school year. Office of Special Education, June 30, 1999.

Number of students is the "resident average daily membership" as calculated by the RI Department of Elementary and Secondary Education.

Other includes deaf and blind, visually impaired or blind, hearing disorders, multi-handicapped, autistic, and traumatic brain injury.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is the number of students enrolled in the school district.

References

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Fourth-Grade Reading Skills

DEFINITION

Fourth-grade reading skills is the percentage of fourth-grade students who scored at or above the proficiency level for reading in the New Standards English Language Arts Reference Exam in 1999. The exam is made up of two parts: "Basic Understanding" focuses on the student's ability to comprehend and understand text, and "Analysis and Interpretation" focuses on the student's ability to correctly interpret and analyze text.

SIGNIFICANCE

Reading skills are critical to a student's success in school and in the workforce. Students who cannot read are more likely to be absent from school, exhibit behavior problems, have low levels of self-confidence, and perform poorly in school.[1] Parent education, language proficiency, family structure, and the community's socioeconomic status are strong predictors of student achievement in reading.[2,3,4]

Children's academic achievement is higher when they live in communities that provide supportive environments for parenting, provide access to high-quality early childhood programs, and have a variety of out-of school learning opportunities for both adults and children.[5] In the U.S., Hispanic children face the most barriers to reading proficiency because they are more likely to be poor, less likely to attend pre-school, and more likely to have parents who have not finished high school.[6]

Literacy begins long before children encounter formal school instruction in writing and reading. Parents play a significant role in shaping children's reading abilities by the reading practices and attitudes they convey at home, beginning in the early years.[7] Reading to young children at home and participation in pre-school programs are two factors that make a difference in reading achievement and overall success in school.[8] Young children who attend Head Start, pre-kindergarten, or other center-based preschool programs have higher emerging literacy scores than other 4 year-olds.[9]

A home environment which encourages learning and parent involvement in children's education are important factors in school achievement.[10] According to the National Education Goals Panel, children who report that they regularly read for fun on their own time consistently outperform students who read only what is required of them at school. Children who regularly discuss their reading with family and friends score significantly higher in reading than students who report that they rarely or never do so.[11] Student reading proficiency declines as television viewing increases. Nationally, one out of every five fourth graders watches six or more hours of television daily.[12]

Family Reading to Young Children

◆ In order to develop pre-reading skills, very young children need to have caring relationships with adults who listen and talk to them, tell stories, and share books.[13] Reading to young children promotes language acquisition and correlates with literacy development and, later on, with achievement in reading comprehension and overall success in school.[14]

◆ Nationally in 1996, just over half (57%) of three to five year-olds were read to every day by a family member.[15] The percentage of families who read to their children everyday increased for families of all races between 1991 and 1996.[16]

◆ Families with limited economic resources and parents who are not high school graduates are significantly less likely to have books in the home and to read to their children on a regular basis.[17,18] A study at Hasbro Hospital in Providence of low-income families found that over half of the households had fewer than 10 children's books, and almost a quarter had 10 books total in the home.[19]

◆ Low-income children start first grade with fewer vocabulary words than middle-class children. A study of children from families receiving welfare found that they had half the number of words in their vocabulary at age three as children from professional families. This gap grew over time, and by first grade the children from families receiving welfare had only one-quarter the number of words as children from professional families.[20]

Fourth-Grade Reading Proficiency, Rhode Island, 1998-1999

◆ In the 1998-1999 school year, 84% of Rhode Island fourth-grade students met the reading standard for "Basic Understanding" and 69% of Rhode Island students met the reading standard for "Analysis and Interpretation."

Source: RI Department of Elementary and Secondary Education, *New Standards English Language Arts Reference Exam at Grade 4*, 1998-1999 school year.

Table 27

Fourth-Grade Reading Proficiency, Rhode Island, 1999

SCHOOL DISTRICT	COMMUNITY CONTEXT			NUMBER OF 4TH GRADE TEST TAKERS	% OF 4TH GRADE STUDENTS MEETING STANDARD FOR BASIC UNDERSTANDING	% OF 4TH GRADE STUDENTS MEETING STANDARD FOR ANALYSIS & INTERPRETATION
	% ADULTS COMPLETING HIGH SCHOOL	% LOW INCOME STUDENTS	% LIMITED ENGLISH PROFICIENCY			
Barrington	89%	2%	0%	257	95%	89%
Bristol Warren	NA	27%	5%	280	84%	65%
Burrillville	71%	17%	0%	231	77%	69%
Central Falls	47%	100%	31%	209	64%	44%
Chariho	82%	13%	0%	306	91%	77%
Coventry	74%	15%	0%	428	89%	77%
Cranston	74%	20%	5%	879	89%	77%
Cumberland	75%	13%	0%	417	86%	75%
East Greenwich	90%	6%	0%	169	97%	88%
East Providence	67%	33%	5%	515	85%	71%
Exeter-W. Greenwich	78%	13%	0%	164	91%	72%
Foster	82%	14%	0%	61	93%	67%
Foster-Glocester	83%	8%	0%	NA	NA	NA
Glocester	83%	18%	0%	143	92%	83%
Jamestown	89%	6%	0%	78	97%	86%
Johnston	67%	18%	1%	276	87%	70%
Lincoln	76%	10%	1%	290	87%	73%
Little Compton	86%	11%	0%	44	95%	84%
Middletown	85%	20%	1%	212	86%	71%
Narragansett	87%	14%	1%	140	94%	83%
Newport	84%	45%	2%	224	100%	57%
New Shoreham	94%	10%	0%	7	78%	59%
North Kingstown	86%	13%	1%	344	94%	81%
North Providence	71%	20%	2%	310	86%	68%
North Smithfield	72%	10%	0%	130	89%	78%
Pawtucket	62%	62%	11%	772	78%	56%
Portsmouth	86%	7%	0%	217	92%	86%
Providence	63%	80%	20%	1,683	65%	43%
Scituate	84%	10%	0%	148	83%	73%
Smithfield	81%	7%	0%	212	96%	82%
South Kingstown	86%	11%	0%	343	90%	79%
Tiverton	71%	14%	0%	168	92%	79%
Warwick	78%	18%	1%	895	92%	79%
Westerly	76%	18%	1%	288	83%	68%
West Warwick	70%	34%	4%	275	91%	76%
Woonsocket	56%	59%	5%	482	79%	62%
Core Cities	*NA*	*73%*	*16%*	*3,370*	*NA*	*NA*
Remainder of State	*NA*	*17%*	*2%*	*8,227*	*NA*	*NA*
Rhode Island	*72%*	*35%*	*6%*	*11,597*	*84%*	*69%*

Source of Data for Table/Methodology

Low-income students are the percentage of students eligible for free/reduced price lunch in 1999. Percent of adults completing high school are based on U.S. Bureau of the Census, 1990 Census of Population. All other data are from the RI Department of Elementary and Secondary Education, 1999. Core cities are Providence, Pawtucket, Central Falls, Woonsocket and Newport. NA: Community has a regional high school.

References for Indicator

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School Attendance

DEFINITION

School attendance is the average daily attendance of all public school students in kindergarten through 12th grade for each school district in Rhode Island.

SIGNIFICANCE

Poor school attendance affects school achievement for young children as well as teenagers. Younger children miss the opportunity to develop important academic skills and to make connections with peers and teachers. Attendance rates are linked to lower reading scores and are an important factor in variation in states' mathematics scores.[1,2] High school students who habitually miss school are more likely to drop-out which in turn affects their future employment potential.[3] Truancy among teens is a powerful predictor of juvenile delinquency.[4]

Problems with student attendance create a climate of instability in schools. In schools where truancy rates are low, there is less disruption and violence. Teachers are more committed to students and are more likely to interact and engage with the entire class. Students are less likely to miss school when they are engaged and have a sense of belonging.[5]

Student absenteeism places individual children at risk for school failure. Failure to attend school is often the first sign to parents and schools that a child is in trouble.[6] Children miss school for a variety of reasons. Instability at home resulting from frequent residential moves and family crisis or a parent's illness often contribute to poor attendance.[7] Teens report that a sense of failure, alienation from school, irrelevant courses and suspensions contribute to their decision to skip school.[8,9] Poor attendance may also signal drug use, emotional and mental health problems, and peer pressure to miss school.[10]

Because the reasons for poor attendance are diverse, truancy prevention programs are most effective when they use a variety of methods to increase attendance. Successful efforts combine strategies that support parents in their responsibility to ensure that their children attend school, motivate children to attend school regularly, and engage teachers in efforts to increase attendance. Truancy reduction strategies include clear consistently enforced school policies; school reorganization to increase students' engagement and attachment to school; improved school-parent communication; family counseling programs; and collaboration between schools and community partners.[11]

National Trends in School Truancy

◆ In 1997, 25% percent of public school principals in the U.S. reported absenteeism to be a serious or moderate problem.[12]

◆ In 1996 in the U.S., 23% of eighth graders and 26% of 12th graders were absent from school three or more days in the preceding month.[13]

◆ Absenteeism is more of a problem in larger schools and urban schools. In a 1997 study, 53% of large schools reported it as a problem compared to 19% of smaller schools.[14] Absentee rates are highest in central city schools and increase with the rates of student poverty.[15]

◆ Poor attendance rates are directly associated with parents' education level. Students whose parents did not graduate from high school are nearly twice as likely to have poor attendance compared to students whose parents graduated from college.[16]

Student Mobility and Attendance

◆ Many families must move often because they cannot secure quality, affordable housing. Studies suggest that there are strong connections between lack of housing, family instability, frequent moves, school attendance, and school performance.[17]

◆ Students who make frequent school changes can experience inappropriate placement in a new school, lack of continuity of lesson content, disruptions in social ties, and feelings of alienation. Teachers may also find it difficult to identify and meet the academic and social needs of the highly mobile student.[18] Students who frequently change schools have lower achievement scores than those who do not, demonstrate poor adjustment, and are suspended more often.[19]

◆ A study of Providence students entering first grade in 1987 found that only 45% were still with their peers by 5th grade and fewer than 25% progressed with their peers to 12th grade. By twelfth grade, more than half of the 1,845 children who entered first grade in 1987, had either moved to another community, transferred to a private school, returned to their family of origin, or dropped out of school altogether.[20]

Table 28.

School Attendance Rate, Rhode Island, 1999

SCHOOL DISTRICT	NUMBER OF STUDENTS ENROLLED	ATTENDANCE RATE
Barrington	3,099	95.4%
Bristol-Warren	3,911	92.8%
Burrillville	2,960	93.9%
Central Falls	3,268	90.3%
Chariho	3,885	94.9%
Coventry	5,475	94.2%
Cranston	10,784	93.0%
Cumberland	4,898	95.0%
East Greenwich	2,242	95.5%
East Providence	6,620	92.7%
Exeter-W. Greenwich	2,058	94.8%
Foster	399	95.2%
Foster-Glocester	1,564	93.3%
Glocester	853	95.8%
Jamestown	662	95.3%
Johnston	3,492	89.9%
Lincoln	3,653	95.4%
Little Compton	354	94.1%
Middletown	2,809	94.6%
Narragansett	1,882	95.1%
Newport	3,020	91.9%
New Shoreham	144	92.8%
North Kingstown	4,536	94.7%
North Providence	3,511	93.4%
North Smithfield	1,787	95.4%
Pawtucket	9,951	91.9%
Portsmouth	2,763	95.5%
Providence	26,147	87.1%
Scituate	1,728	95.1%
Smithfield	2,727	95.1%
South Kingstown	4,270	94.6%
Tiverton	2,190	93.5%
Warwick	12,138	94.1%
Westerly	3,598	94.7%
West Warwick	3,696	92.3%
Woonsocket	6,636	91.4%
Core Cities	***49,022***	*NA*
Remainder of State	***104,688***	*NA*
Rhode Island	***153,710***	*92.5%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 1998-1999 school year.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the total number of students enrolled in the school district.

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Suspensions

DEFINITION

Suspensions is the number of infractions and disciplinary actions for Rhode Island public school students — kindergarten through twelfth grade — during the 1998-1999 school year. Disciplinary actions include in-school suspensions, out-of-school suspensions, alternative placements, and expulsions.

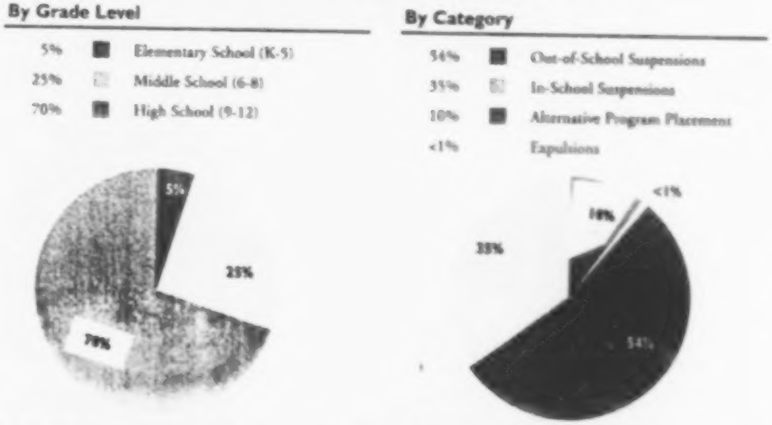
SIGNIFICANCE

Effective school discipline strategies focus on ensuring the safety of students and staff, encouraging responsible behavior, and creating an environment conducive to learning.[1] The most common discipline problems in schools involve non-criminal student behavior that is disruptive of the learning environment. Serious student misconduct involving violent and criminal behavior is relatively infrequent — but may have immediate and long-lasting impact on the quality of the school environment.[2] Schools may take any number of actions when a student is disruptive or threatens the safety and learning of other students.[3] Three-quarters of the schools in the U.S. report having a "zero-tolerance" policy, most often for serious student offenses such as weapon or drug possession.[4]

Students who dislike school, do poor academically, and have limited career objectives are more likely to be disruptive.[5] Students who are suspended from school are at higher risk for poor academic achievement. A recent national study found that students in grades 8-12 who had committed minor infractions (such as cutting class or tardiness) or more serious offenses (such as fighting or physically abusing a teacher) scored 10 percent lower on achievement tests in mathematics, reading, social science and science than students who did not have discipline problems.[6] Students who have discipline problems are more likely to drop out of school.[7]

Research shows that the best approach to school discipline is a balance between clearly communicated and consistently enforced rules and a climate of concern for students as individuals. Smaller schools — or larger schools divided into "schools within schools" — are better able to address the individual needs of students. Discipline problems are likely to be reduced when schools work to ensure academic success for low-achievers while increasing their involvement and attachment to school. Disciplinary referrals may offer staff opportunities to teach students valuable social skills that will lead to success in school as well as in future employment.[8]

Disciplinary Actions, Rhode Island Public Schools, 1998-1999



◆ During the 1998-1999 school year, there were 44,731 incidents in which a Rhode Island public school student received a suspension, alternative program placement, or expulsion. More than half of the disciplinary actions during the 1998-1999 were out-of-school suspensions. Fewer than one percent were expulsions; 43 students were expelled.

By Type of Infraction	Number	By Type of Infraction	Number
Minor Offenses*	32,373	Drug Offenses	389
Disorderly Conduct	4,437	Larceny/Theft	378
Fighting	2,689	Weapon Possession	344
Assault	1,654	Vandalism	303
Possession or Use of Tobacco	1,166	Unknown	33
Threat/Intimidation	965		

*Examples of minor offenses include cutting class, skipping detention and tardiness.

◆ The most common category of infractions resulting in disciplinary action in the 1998-1999 school year was minor offenses (determined by each school district's policies), followed by disorderly conduct, fighting, assault, and tobacco possession or use.

◆ Possession of drugs or weapons accounted for 733 disciplinary actions statewide, less than 2% of all infractions.

Source: Rhode Island Department of Elementary and Secondary Education, 1998-1999 school year.

Table 29

Disciplinary Actions, Rhode Island School Districts, 1999

SCHOOL DISTRICT	# OF STUDENTS ENROLLED	TYPE OF DISCIPLINARY ACTION: SUSPENDED OUT-OF-SCHOOL	SUSPENDED IN-SCHOOL	ALTERNATE PROGRAM PLACEMENT	EXPELLED	TOTAL DISCIPLINARY ACTIONS
Barrington	3,099	151	10	0	0	161
Bristol-Warren	3.911	774	782	2	6	1,564
Burrillville	2.960	568	229	505	0	1,302
Central Falls	3.268	587	406	4	0	997
Chariho	3,885	1,290	2.388	23	0	3,701
Coventry	5.475	221	4.761	0	0	4,982
Cranston	10.784	2.216	9	0	1	2,226
Cumberland	4.898	408	24	0	0	432
East Greenwich	2.242	134	226	0	0	360
East Providence	6.620	369	0	0	0	369
Exeter-W. Greenwich	2.058	131	6	249	0	386
Foster-Glocester	1.564	290	0	0	0	290
Glocester	853	3	0	0	0	3
Johnston	3.492	896	16	0	1	913
Lincoln	3.653	381	660	0	0	1,041
Middletown	2.809	357	782	7	0	1,146
Narragansett	1,882	288	65	2	0	355
Newport	3.020	749	6	16	0	771
New Shoreham	144	0	4	0	0	4
North Kingstown	4.536	553	123	33	0	709
North Providence	3.511	632	30	0	0	662
North Smithfield	1.787	151	0	0	0	151
Pawtucket	9.951	855	292	0	0	1,147
Portsmouth	2.763	73	2	418	0	493
Providence	26,147	5,017	741	4	35	5,797
Scituate	1.728	30	565	0	0	595
Smithfield	2.727	224	5	0	0	229
South Kingstown	4.270	224	2	0	0	226
Tiverton	2.190	334	1.413	26	0	1,773
Warwick	12.138	3.402	8	3.278	0	6.688
Westerly	3.598	227	478	2	0	707
West Warwick	3.696	791	859	2	0	1.652
Woonsocket	6.636	1.795	883	0	0	2.678
State-Operated	1.103	188	3	0	0	191
Core Cities	***49.022***	***9,003***	***2,328***	***24***	***35***	***11,390***
Remainder of State	***104.376***	***15,306***	***13,450***	***4,547***	***8***	***33,311***
Rhode Island	***153.398***	***24,309***	***15,778***	***4,571***	***43***	***44,701***

Note to Table

Total disciplinary actions is the number of incidents resulting in suspension - either in-school or out-of-school, alternate program placement, or expulsion. It does not reflect the total number of students disciplined because each student can receive more than one disciplinary action during the school year. The 44,731 suspensions reported can be attributed to approximately 16,000 students. Table totals to 44,701 due to missing data on 30 cases.

Suspension policies vary by district. The type of disciplinary action imposed for each type of infraction varies according to school district policy. The definition of an infraction that results in disciplinary action also varies according to school district policy.

State operated schools are the Rhode Island School for the Deaf, Davies Vocational Technical School, and Metropolitan Career Tech.

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 1998-1999 school year.

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High School Graduation Rate

DEFINITION

High school graduation rate is the percentage of the ninth-grade class that is expected to graduate, based on the existing drop-out incidence among 9th, 10th, 11th, and 12th grade students. The rate is computed using fall enrollment data and the number of students who dropped out between October 2, 1997 and October 1, 1998. It is a four-year cumulative rate and represents the probability of an individual student graduating from high school.

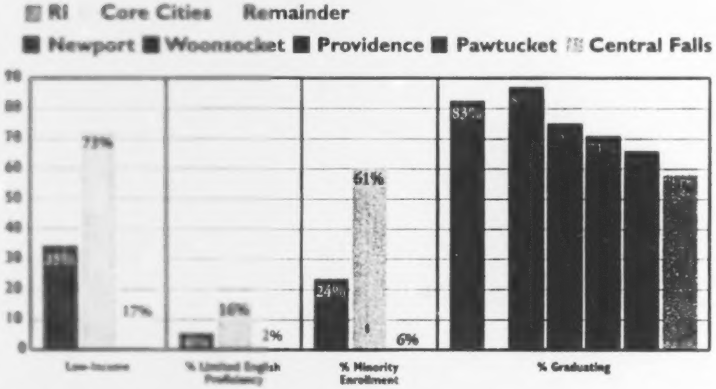
SIGNIFICANCE

Children who receive a quality education are more likely to grow into capable, self-sufficient adults who contribute to their communities. Social background factors such as limited English proficiency, family income, parent education, and family structure are associated with various levels of educational access and different educational outcomes.[1] Children and teens in economically disadvantaged communities are more likely to drop out of school.[2]

Student achievement can be improved when schools have high expectations for all students; have effective and up-to-date curricula and teaching methods; prepared and sufficiently supported teachers; strong home/school linkages; adequate accountability systems; and effective and equitable allocation of resources.[3] Early warning signs for a student likely to drop out of school include inability to read at grade level, poor grades, frequent truancy, and behavior problems.[4] Students can benefit from access to a broad range of community supports that address academic issues, health problems, inadequate nutrition, neighborhood and family violence, and other factors that can disrupt school performance.[5]

Schools in low-income communities often have more limited access to up-to-date instructional materials, adequate classroom space, well-equipped libraries, laboratories, computers, and after-school sports and cultural activities.[6] Nationally, many children of color attend segregated schools with high concentrations of poverty and fewer resources. Hispanic children attend the most severely segregated schools.[7] Hispanic youth have lower high school completion rates than either black, non-Hispanic or white, non-Hispanic youth.[8] A recent national study found that an intensive high school curriculum had the strongest effect on African-American and Hispanic students' success in college; this factor was more significant than test scores, grade point averages, or class rank.[9]

Rhode Island Public School Students, Core Cities, Remainder of State, and Rhode Island, 1998-1999



Source: RI Department of Elementary and Secondary Education, 1999. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

◆ Achievement differences among school districts, and among schools within a district, are correlated with the socio-economic status of the community or neighborhood. There are currently major contrasts in educational achievement and student outcomes depending on where a student lives and goes to school.[10]

◆ Changes in the economy have increased the financial costs of dropping out of school. High school completion has become a requirement for entering additional education, training, or the labor force.[11] More advanced skills and technological knowledge are required for an information-based economy.[12]

◆ High school dropouts are more likely to be unemployed, to be on public assistance and to earn less money than high school graduates.[13] In 1997, the median annual earnings for adults ages 25-34 who had not completed high school were 29% lower for males and 37% lower for females than those who had graduated.[14]

◆ The poverty rate for high school dropouts is ten times that of college graduates. Research shows that school completion and academic success increase children's ability to escape poverty, form strong families, and raise successful children of their own.[15]

High School Graduation Rate

Table 30

High School Graduation Rate, Rhode Island, 1999

SCHOOL DISTRICT	% LOW-INCOME STUDENTS	COMMUNITY CONTEXT % ADULTS COMPLETING HIGH SCHOOL	NUMBER OF STUDENTS ENROLLED	% LIMITED ENGLISH PROFICIENCY	% MINORITY ENROLLMENT	% OF STUDENTS TAKING THE SAT	1999 GRADUATION RATE
Barrington	2%	89%	3,099	0%	3%	84%	94%
Bristol-Warren	27%	NA	3,911	5%	2%	59%	81%
Burrillville	17%	71%	2,960	0%	1%	48%	90%
Central Falls	100%	47%	3,268	31%	67%	36%	58%
Chariho	13%	82%	3,885	0%	3%	52%	86%
Coventry	15%	74%	5,475	0%	3%	54%	86%
Cranston	20%	74%	10,784	5%	13%	53%	85%
Cumberland	13%	75%	4,898	0%	4%	60%	92%
East Greenwich	6%	90%	2,242	0%	3%	86%	83%
East Providence	33%	67%	6,620	5%	16%	58%	79%
Exeter-W. Greenwich	13%	78%	2,058	0%	2%	68%	85%
Foster	14%	82%	399	0%	2%	NA	NA
Foster-Glocester	8%	83%	1,564	0%	2%	58%	89%
Glocester	18%	83%	853	0%	1%	NA	NA
Jamestown	6%	89%	662	0%	2%	NA	NA
Johnston	18%	67%	3,492	1%	6%	55%	88%
Lincoln	10%	76%	3,653	1%	5%	64%	94%
Little Compton	11%	86%	354	0%	0%	NA	NA
Middletown	20%	85%	2,809	1%	12%	68%	95%
Narragansett	14%	87%	1,882	1%	4%	76%	91%
Newport	45%	84%	3,020	2%	34%	68%	87%
New Shoreham	10%	94%	144	0%	4%	100%	90%
North Kingstown	13%	86%	4,536	1%	5%	76%	91%
North Providence	20%	71%	3,511	2%	10%	55%	85%
North Smithfield	10%	72%	1,787	0%	2%	75%	94%
Pawtucket	62%	62%	9,951	11%	39%	46%	66%
Portsmouth	7%	86%	2,763	0%	5%	78%	95%
Providence	80%	63%	26,147	20%	79%	77%	71%
Scituate	10%	84%	1,728	0%	2%	81%	92%
Smithfield	7%	81%	2,727	0%	2%	80%	91%
South Kingstown	11%	86%	4,270	0%	9%	83%	86%
Tiverton	14%	71%	2,190	0%	2%	67%	85%
Warwick	18%	78%	12,138	1%	4%	63%	92%
Westerly	18%	76%	3,598	1%	5%	60%	89%
West Warwick	34%	70%	3,696	4%	8%	51%	82%
Woonsocket	59%	56%	6,636	5%	31%	49%	75%
Core Cities	***73%***	***NA***	***49,022***	***16%***	***61%***	***62%***	***NA***
Remainder of State	***17%***	***NA***	***104,688***	***2%***	***6%***	***62%***	***NA***
Rhode Island	***35%***	***72%***	***153,710***	***6%***	***24%***	***62%***	***83%***

Source of Data for Table/Methodology

% low-income students is the percentage of students eligible for free/reduced price lunch in 1999.

Percent of adults completing high school is from the 1990 Census of Population. All other data are from the Rhode Island Department of Elementary and Secondary Education, 1998-1999 school year.

NA: Community has a regional high school. The denominator is the number of children enrolled in 9th, 10th, 11th and 12th grades in the fall of 1998.

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Teens Not in School and Not Working

DEFINITION

Teens not in school and not working is the percentage of teens ages 16 to 19 who are not enrolled in school, not in the Armed Forces, and not employed. This indicator includes recent high school graduates who are unemployed, and teens who have dropped out of high school and are jobless.

SIGNIFICANCE

Dropping out of school and not becoming part of the workforce places teens at a significant disadvantage as they transition from adolescence to adulthood. These adolescents have a difficult time getting connected to the job market as young adults and have a less stable employment history than their peers who stayed in school or secured jobs.[4] In 1997, 8% of Rhode Island teens ages 16 to 19 were neither enrolled in school nor working.[5] This group of teens is at especially high risk for teen parenting, crime, negative behaviors, and limited economic prospects.[6] They are likely to lack credible references, have little confidence in their abilities, and lack knowledge about job opportunities.[7]

Many school and community programs do not adequately address the needs of students on the verge of dropping out of school and out-of-school youth.'[8] All youth need opportunities to develop basic skills, such as math, reading and writing, as well as to develop other qualities that will help them to find a job, including problem-solving, creativity, self-motivation, and responsibility.[9] Ongoing relationships with caring adults and connections within the family and community are powerful factors in protecting young people from negative behaviors, encouraging good social skills, responsible values, and positive identity.[10]

For those likely to drop out of school with no connection to the job market, school-linked part-time jobs can be an important resource to prevent dropping-out, reinforce learning in school, and develop positive work attitudes and habits.[11] The most effective of the current generation of school-to-work programs have positive effects on students attitudes toward work, school attendance, and drop-out rates.[12]

Out-of-School Youth: National Trends

◆ The percentage of black and Hispanic youth ages 16 to 19 who are neither employed nor in school exceeds that of white youth. In 1998, 13% of black youth, 14% of Hispanic youth and 7% of white youth were neither in school nor employed.[13]

◆ Older youth ages 18 to 19 are three times more likely to be neither in school nor working than youth ages 16 and 17.[14]

◆ The percentage of young women who are neither employed nor in school has fallen substantially in the 1990's. Between 1991 and 1998, the percentage declined from 13% to 9%.[15] For black and Hispanic women, much of the decrease over the 1990's can be accounted for by increases in school enrollment.[16]

Connecting Youth to School and Work

◆ Safe places in the community that offer productive activities for teens can connect youth to caring adults, strengthen teens' commitment to school, and provide opportunities for young people to contribute to their community and society.[17]

◆ Opportunities that focus on job advancement and income gains, as well as on getting employment, are especially important to minority youth and to women. Effective programs for out-of-school youth can bridge race and gender barriers and provide an entry point into better paying occupations.[18]

◆ Many middle-class teens get their jobs through a network of informal contacts. Low-income teens are less likely to have these kinds of connections with employers and places of employment. Effective programs for out-of-school youth seek to construct (or reconstruct) these networks.[19]

Teens Not in School and Not Working

Table 31. **% Teens Not in School and Not Working, Ages 16-19, Rhode Island, 1990**

CITY/TOWN	TOTAL NUMBER OF TEENS AGES 16-19	JOBLESS HIGH SCHOOL GRADUATES	JOBLESS NON-HIGH SCHOOL GRADUATES	TOTAL NUMBER OF JOBLESS TEENS	% OF TEENS WHO ARE JOBLESS
Barrington	800	8	17	25	3.1%
Bristol	1,703	43	34	77	4.5%
Burrillville	886	33	31	64	7.2%
Central Falls	931	35	100	135	14.5%
Charlestown	261	0	0	0	0.0%
Coventry	1,689	59	52	111	6.6%
Cranston	3,500	119	304	423	12.1%
Cumberland	1,474	59	128	187	12.7%
East Greenwich	627	0	7	7	1.1%
East Providence	2,408	72	180	252	10.5%
Exeter	279	16	17	33	11.8%
Foster	232	16	3	19	8.2%
Glocester	565	27	27	54	9.6%
Hopkinton	377	10	44	54	14.3%
Jamestown	226	0	10	10	4.4%
Johnston	1,235	13	30	43	3.5%
Lincoln	874	32	17	49	5.6%
Little Compton	167	0	4	4	2.4%
Middletown	922	20	27	47	5.1%
Narragansett	653	15	16	31	4.7%
Newport	1,978	56	46	102	5.2%
New Shoreham	20	0	0	0	0.0%
North Kingstown	1,269	12	30	42	3.3%
North Providence	1,444	29	78	107	7.4%
North Smithfield	578	30	0	30	5.2%
Pawtucket	3,632	81	303	384	10.6%
Portsmouth	851	10	13	23	2.7%
Providence	12,841	254	1,042	1,296	10.1%
Richmond	284	18	16	34	12.0%
Scituate	555	24	10	34	6.1%
Smithfield	1,625	21	16	37	2.3%
South Kingstown	3,818	15	7	22	0.6%
Tiverton	812	34	24	58	7.1%
Warren	505	0	37	37	7.3%
Warwick	4,231	151	198	349	8.2%
Westerly	992	10	108	118	11.9%
West Greenwich	211	15	0	15	7.1%
West Warwick	1,478	46	89	135	9.1%
Woonsocket	2,357	101	285	386	16.4%
Core Cities	***21,739***	***527***	***1,776***	***2,303***	***10.6%***
Remainder of State	***37,551***	***957***	***1,574***	***2,531***	***6.7%***
Rhode Island	***59,290***	***1,484***	***3,350***	***4,834***	***8.1%***

Sources of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of teens ages 16 to 19 according to the 1990 Census of Population.

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Methodology and Acknowledgements

Methodology

The *2000 Rhode Island KIDS COUNT Factbook* examines thirty-seven indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. The information on each indicator is organized as follows:

- ◆ ***Definition:*** A description of the indicator and what it measures.
- ◆ ***Significance:*** The relationship of the indicator to child and family well-being.
- ◆ ***Sidebars:*** Current state and national data and information related to the indicator.
- ◆ ***City/Town Tables:*** Data for each indicator presented for each of Rhode Island's cities and towns, the state as a whole, and the core cities.
- ◆ ***Core Cities Data:*** Five core cities are identified based on high child poverty rates: Providence, Pawtucket, Woonsocket, Newport, and Central Falls. These are the only Rhode Island communities in which more than 15% of the children live below the poverty level, according to the 1990 Census.
- ◆ ***Most Recent Available Data:*** The *2000 Factbook* uses the most current, reliable data available for each indicator.
- ◆ ***New Indicators:*** Seven new indicators have been added to the thirty indicators included in the *1999 Rhode Island KIDS COUNT Factbook*: "Children Receiving Child Support," "Access to Dental Care," "Children and Domestic Violence," "Child Care Subsidies," "Full-Day Kindergarten," "School Attendance," "Suspensions."

The *2000 Rhode Island KIDS COUNT Factbook* presents the data for each indicator using numbers, rates, and/or percentages.

Numbers

The most direct measure of the scope of a problem is the count of the number of events of concern during a specified time period — e.g. the number of child deaths between 1994 and 1998.

Numbers are important in assessing the scope of the problem and in estimating the resources required to address a problem. Numbers are not useful to compare the severity of the problem from one geographic area to another or to compare the extent of the problem in your state with national standards. For example, a state with more children might have more low birthweight infants due to the larger number of total births, not due to an increased likelihood of being born low birthweight.

Rates and Percentages

A rate is a measure of the probability of an event — e.g. out of every 1,000 live births, how many infants will die before their first birthday?

A percentage is another measure of the probability of an event — e.g. out of every 100 births, how many will be born low birthweight?

Rates and percentages take into account the total population of children eligible for an event. They are useful in comparing the severity of the problem from one geographic area to another, to compare with state or national standards, or to look at trends over time.

Sources of Data and Methodology for Calculating Rates and Percentages

For each indicator, the source of information for the actual number of events of interest (the "numerator") are identified within the Source of Data/Methodology section next to the table for that indicator. For each indicator that uses a rate or a percentage, the methodology used to estimate the total number of children eligible for the indicator of interest (i.e. the "denominator") is also noted within the Source of Data/Methodology section.

Rates and percentages were not calculated for cities and towns with small denominators (less than 500 for delayed prenatal care, low birthweight infants, and infant mortality rates and less than 100 for births to teens). Rates and percentages for small denominators are statistically unreliable. "NA" is noted in the indicator table when this occurs. In the indicator for child deaths and teen deaths, the indicator events are rare; in these instances, city and town rates are not calculated, as small numbers make these rates statistically unreliable.

Methodology for GeoLytics Estimates of 1999 Child Population

Child population for children under age 18 in 1999 are from GeoLytics, Inc.,"CensusCD + Maps," Version 3.0, Estimates and Projections Tables.

Data for Rhode Island cities and towns are the result of aggregating GeoLytics 1999 estimates for block groups up to census tracts and then aggregating census tracts to cities and towns. Direct city/town estimates are not possible using GeoLytics 1999. Aggregation of tract level data to state totals produces results that are significantly lower than state totals furnished by GeoLytics. Block group data aggregate to state totals that match those from GeoLytics.

Methodology for Infant and Preschool Child Care Indicator

Estimated Number of Children in Need of Regulated Child Care: The denominator is the potential number of children in need of regulated care and is computed by: a.) multiplying the 1990 Census number of children under age 6 with mothers in the workforce by 47% (the percentage of U.S. women with children under age 6 who use center-based care or family child care homes as their child care arrangement), and adding it to b.) the number of 1 to 5 year olds living in families enrolled in the Family Independence Program as of December, 1999 that has been multiplied by 50% (assuming half of FIP mothers will work), and then multiplied by 75% (the percentage of families receiving child care subsidies in Rhode Island who choose center-based care or families child care homes as their child care arrangement). The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots as of December 1999. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Methodology for Child Care Subsidies Indicator

Number of Child Care Subsidies by City and Town: The number of children receiving child care subsidies in a licensed child care center or a certified family child care home is the total number of children for whom the Rhode Island Department of Human Services paid a full or part-time subsidy as of December 15, 1999. All data are based on the location of the child care program where the child receives services, not the residence of the child. Two child care programs, Child Care Connection and Child, Inc., have multiple centers and receive payment for all children at a central business office, not at the location of the center. For these programs, the number of children using subsidies in each city or town are estimates based on the percentage of total children using subsidies in each center as of January 2000.

Estimated Number of Children Under Age 16 Eligible for Child Care Subsidies: The number of children under age 16 in working families under 185% of the Federal Poverty Level (FPL) is computed by: a.) multiplying the 1990 Census percentage of women in the labor force with children under age 18 by the number of Rhode Island children under age 16 in 1999 (as computed by GeoLytics methodology) to get the total number of children under age 16 with mothers in the workforce; b.) The total number of children under age 16 with mothers in the workforce is multiplied by the percentage of children under 185% FPL (children eligible for free or reduced price school lunch) to get the estimated number of children under age 16 in working families under 185% of the FPL.

Limitations of the Data

In any data collection process there are always concerns about the accuracy and completeness of the data being collected. All data used in the 37 indicators were collected through the U.S. Bureau of the Census and through routine data collection systems operated by different agencies of the state of Rhode Island. We do not have estimates of the completeness of reporting to these systems.

In all cases, we used the most reliable data currently available. For census-based indicators, statewide numbers have been updated to 1997 using the Current Population Survey, 1995-1999 average. The Current Population Survey does not provide data at the level of city and town. City/town tables, therefore, use information from the 1990 Census of Population or Geolytics.

We expect that over time the data used to assess child well-being in Rhode Island will be more timely and will contain more complete information on the state's racial and ethnic communities than is currently available.

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Children and Domestic Violence: Deborah DeBare, Francie Mantak, Rhode Island Coalition Against Domestic Violence; Wendy Verhoek-Oftedahl, Rhode Island Department of Health; Janice Dubois, RI Supreme Court Domestic Violence Training and Monitoring Unit; Eric Hirsch, Providence College.

Infant and Pre-School Child Care, Child Care Subsidies and School-Age Child Care: Patricia Nolin, Options for Working Parents; Barbara Burgess, Rhode Island Department of Education; Alexandra Moser, Office of Child Care, Diocese of Providence; Mary Ann Shallcross, Child Care Connection; Larry Pucciarelli, Sherry Campanelli, Reeva Sullivan Murphy, Randy Rosati, Carol Ponto, Rhode Island Department of Human Services; Representative Nancy Benoit; Nancy Gewirtz, Rhode Island College School of Social Work; Barbara Cavallaro, Rhode Island Child Care Director's Association; Joyce Butler, Maryann Finamore, Rhode Island Public Policy Coalition for Child Care; Sue Connor, Rhode Island Association for the Education of Young Children; Lenette Azzi-Lessing, Teri DeBoise, Children's Friend and Service; Mary Beth Young, Child Care Connection; Lynda Dickinson, Child, Inc.; Patricia Martinez, Progreso Latino; Tom Anton, Eleanor McMahon, Jack Combs, A. Alfred Taubman Center, Brown University; Julia Steiny, Robert Felner, Lynda Hurditch, National Center for Public Education, URI.

Children Enrolled in Head Start: Larry Pucciarelli, Sherry Campanelli, RI Department of Human Services; Roy Walker, Administration for Children and Families; Jeanne Rheaume, Cranston Child Development Program; Pamela Caldwell, Lynda Dickinson, Child, Inc.; Sister Barbara McMichael, Carol Cooper, Providence Head Start; Lori Richard and Carol Hemingway, South County Head Start; Mary Nugent, East Bay Head Start; Sue Perry, Cindy Larson, New Visions Head Start; Susan Connaughton, Amy Lapierre, Tritown Head Start; Karen Bouchard, Woonsocket Head Start; Lenette Azzi-Lessing, Teri DeBoise, Children's Friend and Service; Eleanor McMahon, A. Alfred Taubman Center, Brown University; Karen Pucciarelli, Susan Washburn, New England Resource Center.

Full-Day Kindergarten: Virginia daMota, Barbara Burgess, Terry Bergner, Rick Richards, RI Department of Education.

School Attendance: Terry Bergner, RI Department of Education; Patrick McGuigan, The Providence Plan; Michael Jolin, Superintendent, West Warwick School District.

Fourth-Grade Reading Skills: Terry Bergner, Dennis Cheek, James Karon, Diane DiSanto, Karen Cooper, Virginia da Mota, Cynthia Corbridge, Pat DeVito, Paula Rossi, Jane Correia, Mary Ellen Sacco, RI Department of Education; Karen Voci, The Rhode Island Foundation; Julia Steiny, Robert Felner, National Center for Public Education, URI.

Suspensions: Terry Bergner, George McDonough, RI Department of Education.

Children Enrolled in Special Education: Michael Msall, MD, RI Hospital Child Development Center; Fredericka Bettinger; Dennis Cheek, Terry Bergner, Charlene Gilman, Robert Pryhoda, Barbara Burgess, Karen Cooper, RI Department of Education; William Hollinshead, MD, Samara Viner-Brown, Peter Simon, MD, David Hamel, RI Department of Health; John A.Y. Andrews, Rhode Island Department of Human Services; Martha McVicker, RI Disability Law Center; Dawn Wardyga, Family Voices.

High School Graduation Rate: Jane Nugent, United Way of Southeastern New England; Robert Wooler, RI Youth Guidance Center; Lenette Azzi-Lessing, Children's Friend and Service; Dennis Cheek, Terry Bergner, George McDonough, Karen Cooper, Virginia da Mota, Cynthia Corbridge, Pat DeVito, Paula Rossi, Jane Correia, Mary Ellen Sacco, Terry Bergner, RI Department of Education; Karen Voci, The Rhode Island Foundation.

Teens Not in School and Not Working: Judy Marmaras, RI Department of Employment and Training; Maria Ferreira, RI Department of Labor and Training; Jack Combs, Brown University; John Cronin, Greater RI Regional Training Board; Ron Millican, West Bay Collaborative.

Poetry Credits

"Stars" by Sara Teasdale, reprinted from *Time for Poetry* (1952). Chicago: Scott, Foresman and Company.

"Warrior Nation Trilogy" by Lance Henson, reprinted from *Imaginary Gardens* (1989). New York: Harry N. Abrams, Inc.

"Earthly Paradise" by Francisco X. Alarcon, reprinted from *Angels Ride Bikes and Other Fall Poems* (1999). San Francisco: Children's Book Press.

"Oath of Friendship", anonymous, reprinted from *Talking to the Sun* (1985). New York: Holt, Rinehart and Winston.

"Quiet Girl" by Langston Hughes, reprinted from *The Dream Keeper and Other Poems* (1932). New York: Alfred A. Knopf.

"High Flight" by John Gillespie Magee, Jr., reprinted from *Imaginary Gardens* (1989). New York: Harry N. Abrams, Inc.

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